Senate Bill No. 1465

Passed the Senate August 21, 2014

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Secretary of the Senate

Passed the Assembly August 19, 2014

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2014, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 8880.5, 14670.3, and 14670.5 of the Government Code, to amend Sections 1728.7, 1797.98b, 127665, and 128225.5 of the Health and Safety Code, to amend and renumber Section 10961 of the Insurance Code, to amend Sections 308, 667.5, and 3000 of the Penal Code, to amend Section 2356 of the Probate Code, and to amend Sections 736, 5328.15, 6600, 6601, 6608.7, 6609, 9717, 10600.1, 10725, 14043.26, 14087.36, 14105.192, 14124.5, 14169.51, 14169.52, 14169.53, 14169.55, 14169.56, 14169.58, 14169.59, 14169.61, 14169.63, 14169.65, 14169.66, 14169.72, 14312, 14451, 15657.8, and 16541 of the Welfare and Institutions Code, relating to health, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 1465, Committee on Health. Health.

(1) Existing law prohibits any private or public organization, political subdivision of the state, or other government agency within the state from providing or arranging for skilled nursing services to patients in the home without first obtaining a home health agency license, as defined, from the State Department of Public Health. Existing law establishes the requirements for licensure as a home health agency. Existing law requires the department to license a home health agency that, among other things, is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program and the accrediting organization forwards to the department certain information.

For purposes of licensure, the bill would instead require a home health agency to be accredited by an entity approved by the federal Centers for Medicare and Medicaid Services as a national accreditation organization.

(2) Existing law authorizes each county to establish an Emergency Medical Services Fund for reimbursement of costs related to emergency medical services. Existing law requires each county establishing a fund to, on January 1, 1989, and each April

15 thereafter, report to the Legislature on the implementation and status of the Emergency Medical Services Fund, as specified.

This bill would instead require each county to submit its reports to the Emergency Medical Services Authority. The bill would require the authority to compile and forward a summary of each county's report to the appropriate policy and fiscal committees of the Legislature.

(3) Existing law, until June 30, 2015, requests the University of California to establish the California Health Benefit Review Program to assess legislation proposing to mandate a benefit or service or to repeal a mandated benefit or service, and to prepare a written analysis with relevant data on specified areas, including public health impacts, medical impacts, and financial impacts.

This bill would extend the repeal date of the above provisions to December 31, 2015.

(4) Existing law requires, until January 1, 2018, and subject to the appropriation of funds in the Budget Act of 2014, the Director of Statewide Health Planning and Development to select and contract on behalf of the state with accredited primary care or family medicine residency programs for the purpose of providing grants to support newly created residency positions, and requires the California Healthcare Workforce Policy Commission to review and make recommendations to the director concerning the provision of those grants. Existing law requires the commission, in making these recommendations, to give priority to residency programs that demonstrate, among other things, that the new primary care physician residency positions have been, or will be, approved by the Accreditation Council for Graduate Medical Education prior to the first distribution of grant funds.

This bill would include primary care physician residency positions that have been, or will be, approved by the American Osteopathic Association in the above-described prioritization provision.

(5) Existing law creates the California Health Benefit Exchange for the purpose of facilitating the enrollment of qualified individuals and small employers in qualified health plans. Existing law requires the Exchange to enter into contracts with and certify as a qualified health plan bridge plan products that meet specified requirements. Existing law provides for the regulation of health insurers by the Department of Insurance and defines a bridge plan

product to include an individual health benefit plan offered by a health insurer. Existing law requires, until 5 years after federal approval of bridge plan products, a health insurer selling a bridge plan product to provide specified enrollment periods and to maintain a medical loss ratio of 85% for the product. Existing law specifies that the remaining provisions of the chapter of law to which these requirements regarding bridge plan products were added became inoperative on January 1, 2014.

This bill would relocate those requirements regarding bridge plan products to a different chapter of law and make other technical, nonsubstantive changes.

(6) Existing law, the Stop Tobacco Access to Kids Enforcement (STAKE) Act, prohibits a minor from purchasing, receiving, or possessing tobacco products or paraphernalia. Existing law prohibits a retailer from knowingly or under circumstances in which it has knowledge, or should otherwise have grounds for knowledge, selling, giving, or in any way furnishing a minor with tobacco products or paraphernalia. Existing law exempts a minor from prosecution for that purchase, receipt, or possession while the minor is participating in a random, onsite sting inspection conducted by the State Department of Public Health as part of its enforcement responsibilities.

This bill would also exempt a minor from prosecution under that act while the minor is participating in an activity conducted by the State Department of Public Health, a local health department, or a law enforcement agency for the purpose of determining or evaluating youth tobacco purchase rates.

(7) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law requires an applicant or provider, as defined, to submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location. Existing law generally requires the department to give written notice as to the status of an application to an applicant or provider within 180 days after receiving an application package, or from the date of notifying an applicant or provider that he or she does not qualify as a preferred provider, notifying the applicant or provider if specified

circumstances apply, or, on the 181st day, to grant provisional provider status to the applicant or provider. Existing law requires the department to send a notice as to the status of an application to an applicant or provider within 60 days after receiving an application package that was noticed as incomplete, was resubmitted with all requested information and documentation, and was received by the department within 60 days of the date on the notice, notifying the applicant or provider if specified circumstances apply.

This bill would, except as specified, authorize an applicant or provider to request to withdraw an application package submitted pursuant to these provisions, and would require the department to notify the applicant or provider, in both above-described notices, if the application package is withdrawn by request of the applicant or provider and the department's review is canceled.

(8) Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to various models of managed care. In this regard, existing law authorizes the City and County of San Francisco to establish a health authority to be the local initiative component of the managed care model in that city and county. Existing law requires that the governing board of the health authority consist of 18 voting members, 2 of which are required to be nominated by the beneficiary committee established by the health authority to advise the authority on issues of concern to the recipients of services. Existing law requires that at least one of the 2 persons nominated by the beneficiary committee be a Medi-Cal beneficiary.

This bill would instead require the health authority to establish a member advisory committee to advise the authority on issues of concern to the recipients of services and would delete the requirement that one of the 2 persons nominated by the committee be a Medi-Cal beneficiary. The bill would instead require the 2 persons nominated by the committee to be enrolled in a health care program operated by the health authority, as specified, or be the parent or legal guardian of an enrollee.

(9) Existing law authorizes the Director of Health Care Services to administer laws pertaining to the administration of health care services and medical assistance throughout the state by, among other things, adopting regulations pursuant to the provisions of the

Administrative Procedure Act to enable the department to carry out the purposes and intent of the Medi-Cal Act.

This bill would correct obsolete cross-references to the Administrative Procedure Act in these provisions, and would make other technical, nonsubstantive changes.

(10) Existing law, subject to federal approval, imposes a hospital quality assurance fee, as specified, on certain general acute care hospitals, to be deposited into the Hospital Quality Assurance Revenue Fund. Existing law, subject to federal approval, requires that moneys in the Hospital Quality Assurance Revenue Fund be continuously appropriated during the first program period of January 1, 2014, to December 31, 2016, inclusive, and available only for certain purposes, including paying for health care coverage for children, as specified, and making supplemental payments for certain services to private hospitals and increased capitation payments to Medi-Cal managed care plans. Existing law also requires the payment of direct grants to designated and nondesignated public hospitals in support of health care expenditures funded by the quality assurance fee for the first program period. For subsequent program periods, existing law authorizes the payment of direct grants for designated and nondesignated public hospitals and requires that the moneys in the Hospital Quality Assurance Revenue Fund be used for the above-described purposes upon appropriation by the Legislature in the annual Budget Act.

This bill would define the term “fund” to mean the Hospital Quality Assurance Revenue Fund for the purposes of these provisions and would make other technical, conforming changes to these provisions.

(11) Existing law provides for state hospitals for the care, treatment, and education of mentally disordered persons, which are under the jurisdiction of the State Department of State Hospitals.

This bill would make technical, nonsubstantive changes to various provisions of law to, in part, delete obsolete references to the State Department of Mental Health. The bill would also make other technical, nonsubstantive changes.

(12) This bill would declare that it is to take effect immediately as an urgency statute.

The people of the State of California do enact as follows:

SECTION 1. Section 8880.5 of the Government Code is amended to read:

8880.5. Allocations for education:

The California State Lottery Education Fund is created within the State Treasury, and is continuously appropriated for carrying out the purposes of this chapter. The Controller shall draw warrants on this fund and distribute them quarterly in the following manner, provided that the payments specified in subdivisions (a) to (g), inclusive, shall be equal per capita amounts.

(a) (1) Payments shall be made directly to public school districts, including county superintendents of schools, serving kindergarten and grades 1 to 12, inclusive, or any part thereof, on the basis of an equal amount for each unit of average daily attendance, as defined by law and adjusted pursuant to subdivision (*l*).

(2) For purposes of this paragraph, in each of the 2008–09, 2009–10, 2010–11, 2011–12, 2012–13, 2013–14, and 2014–15 fiscal years, the number of units of average daily attendance in each of those fiscal years for programs for public school districts, including county superintendents of schools, serving kindergarten and grades 1 to 12, inclusive, shall include the same amount of average daily attendance for classes for adults and regional occupational centers and programs used in the calculation made pursuant to this subdivision for the 2007–08 fiscal year.

(b) Payments shall also be made directly to public school districts serving community colleges, on the basis of an equal amount for each unit of average daily attendance, as defined by law.

(c) Payments shall also be made directly to the Board of Trustees of the California State University on the basis of an amount for each unit of equivalent full-time enrollment. Funds received by the trustees shall be deposited in and expended from the California State University Lottery Education Fund, which is hereby created or, at the discretion of the trustees, deposited in local trust accounts in accordance with subdivision (j) of Section 89721 of the Education Code.

(d) Payments shall also be made directly to the Regents of the University of California on the basis of an amount for each unit of equivalent full-time enrollment.

(e) Payments shall also be made directly to the Board of Directors of the Hastings College of the Law on the basis of an amount for each unit of equivalent full-time enrollment.

(f) Payments shall also be made directly to the Department of the Youth Authority for educational programs serving kindergarten and grades 1 to 12, inclusive, or any part thereof, on the basis of an equal amount for each unit of average daily attendance, as defined by law.

(g) Payments shall also be made directly to the two California Schools for the Deaf, the California School for the Blind, and the three Diagnostic Schools for Neurologically Handicapped Children, on the basis of an amount for each unit of equivalent full-time enrollment.

(h) Payments shall also be made directly to the State Department of Developmental Services and the State Department of State Hospitals for clients with developmental or mental disabilities who are enrolled in state hospital education programs, including developmental centers, on the basis of an equal amount for each unit of average daily attendance, as defined by law.

(i) No Budget Act or other statutory provision shall direct that payments for public education made pursuant to this chapter be used for purposes and programs (including workload adjustments and maintenance of the level of service) authorized by Chapters 498, 565, and 1302 of the Statutes of 1983, Chapter 97 or 258 of the Statutes of 1984, or Chapter 1 of the Statutes of the 1983–84 Second Extraordinary Session.

(j) School districts and other agencies receiving funds distributed pursuant to this chapter may at their option utilize funds allocated by this chapter to provide additional funds for those purposes and programs prescribed by subdivision (i) for the purpose of enrichment or expansion.

(k) As a condition of receiving any moneys pursuant to subdivision (a) or (b), each school district and county superintendent of schools shall establish a separate account for the receipt and expenditure of those moneys, which account shall be clearly identified as a lottery education account.

(*l*) Commencing with the 1998–99 fiscal year, and each year thereafter, for purposes of subdivision (a), average daily attendance shall be increased by the statewide average rate of excused absences for the 1996–97 fiscal year as determined pursuant to the provisions of Chapter 855 of the Statutes of 1997. The statewide average excused absence rate, and the corresponding adjustment factor required for the operation of this subdivision, shall be certified to the Controller by the Superintendent of Public Instruction.

(m) It is the intent of this chapter that all funds allocated from the California State Lottery Education Fund shall be used exclusively for the education of pupils and students and no funds shall be spent for acquisition of real property, construction of facilities, financing of research, or any other noninstructional purpose.

SEC. 2. Section 14670.3 of the Government Code is amended to read:

14670.3. Notwithstanding Section 14670, the Director of General Services, with the consent of the State Department of Developmental Services, may let to a nonprofit corporation, for the purpose of conducting an educational and work program for persons with intellectual disabilities, and for a period not to exceed 55 years, real property not exceeding five acres located within the grounds of the Fairview State Hospital.

The lease authorized by this section shall be nonassignable and shall be subject to periodic review every five years. The review shall be made by the Director of General Services, who shall do both of the following:

(a) Ensure the state that the original purposes of the lease are being carried out.

(b) Determine what, if any, adjustment should be made in the terms of the lease.

The lease shall also provide for an initial capital outlay by the lessee of thirty thousand dollars ($30,000) prior to January 1, 1976. The capital outlay may be, or may have been, contributed before or after the effective date of the act adding this section.

SEC. 3. Section 14670.5 of the Government Code is amended to read:

14670.5. Notwithstanding Section 14670, the Director of General Services, with the consent of the State Department of

Developmental Services may let to a nonprofit corporation, for the purpose of establishing and maintaining a rehabilitation center for persons with intellectual disabilities, for a period not exceeding 20 years, real property, not exceeding five acres, located within the grounds of the Fairview State Hospital in Orange County, and that is retained by the state primarily to provide a peripheral buffer area, or zone, between real property that the state hospital is located on and adjacent real property, if the director deems the letting is in the best interests of the state.

SEC. 4. Section 1728.7 of the Health and Safety Code is amended to read:

1728.7. (a) Notwithstanding any other provision of this chapter, the department shall issue a license to a home health agency that applies to the department for a home health agency license and meets all of the following requirements:

(1) Is accredited as a home health agency by an entity approved by the federal Centers for Medicare and Medicaid Services as a national accreditation organization, and the national accreditation organization forwards to the department copies of all initial and subsequent survey and other accreditation reports or findings.

(2) Files an application with fees pursuant to this chapter.

(3) Meets any other additional licensure requirements of, or regulations adopted pursuant to, this chapter that the department identifies, after consulting with the national accreditation organizations, as more stringent than the accreditation requirements of the national accreditation organizations.

(b) The department may require a survey of an accredited home health agency to ensure the accreditation requirements are met. These surveys shall be conducted using a selective sample basis.

(c) The department may require a survey of an accredited home health agency to investigate complaints against an accredited home health agency for substantial noncompliance, as determined by the department, with these accreditation standards.

(d) Notwithstanding subdivisions (a), (b), and (c), the department shall retain its full range of authority over accredited home health agencies to ensure the licensure and accreditation requirements are met. This authority shall include the entire scope of enforcement sanctions and options available for unaccredited home health agencies.

SEC. 5. Section 1797.98b of the Health and Safety Code is amended to read:

1797.98b. (a) Each county establishing a fund, on January 1, 1989, and on each April 15 thereafter, shall report to the authority on the implementation and status of the Emergency Medical Services Fund. Notwithstanding Section 10231.5 of the Government Code, the authority shall compile and forward a summary of each county's report to the appropriate policy and fiscal committees of the Legislature. Each county report, and the summary compiled by the authority, shall cover the immediately preceding fiscal year, and shall include, but not be limited to, all of the following:

(1) The total amount of fines and forfeitures collected, the total amount of penalty assessments collected, and the total amount of penalty assessments deposited into the Emergency Medical Services Fund, or, if no moneys were deposited into the fund, the reason or reasons for the lack of deposits. The total amounts of penalty assessments shall be listed on the basis of each statute that provides the authority for the penalty assessment, including Sections 76000, 76000.5, and 76104 of the Government Code, and Section 42007 of the Vehicle Code.

(2) The amount of penalty assessment funds collected under Section 76000.5 of the Government Code that are used for the purposes of subdivision (e) of Section 1797.98a.

(3) The fund balance and the amount of moneys disbursed under the program to physicians and surgeons, for hospitals, and for other emergency medical services purposes, and the amount of money disbursed for actual administrative costs. If funds were disbursed for other emergency medical services, the report shall provide a description of each of those services.

(4) The number of claims paid to physicians and surgeons, and the percentage of claims paid, based on the uniform fee schedule, as adopted by the county.

(5) The amount of moneys available to be disbursed to physicians and surgeons, descriptions of the physician and surgeon claims payment methodologies, the dollar amount of the total allowable claims submitted, and the percentage at which those claims were reimbursed.

(6) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

(7) The name of the physician and surgeon and hospital administrator organization, or names of specific physicians and surgeons and hospital administrators, contacted to review claims payment methodologies.

(8) A description of the process used to solicit input from physicians and surgeons and hospitals to review payment distribution methodology as described in subdivision (a) of Section 1797.98e.

(9) An identification of the fee schedule used by the county pursuant to subdivision (e) of Section 1797.98c.

(10) (A) A description of the methodology used to disburse moneys to hospitals pursuant to subparagraph (B) of paragraph (5) of subdivision (b) of Section 1797.98a.

(B) The amount of moneys available to be disbursed to hospitals.

(C) If moneys are disbursed to hospitals on a claims basis, the dollar amount of the total allowable claims submitted and the percentage at which those claims were reimbursed to hospitals.

(11) The name and contact information of the entity responsible for each of the following:

(A) Collection of fines, forfeitures, and penalties.

(B) Distribution of penalty assessments into the Emergency Medical Services Fund.

(C) Distribution of moneys to physicians and surgeons.

(b) (1) Each county, upon request, shall make available to any member of the public the report provided to the authority under subdivision (a).

(2) Each county, upon request, shall make available to any member of the public a listing of physicians and surgeons and hospitals that have received reimbursement from the Emergency Medical Services Fund and the amount of the reimbursement they have received. This listing shall be compiled on a semiannual basis.

SEC. 6. Section 127665 of the Health and Safety Code is amended to read:

127665. This chapter shall remain in effect until December 31, 2015, and shall be repealed as of that date, unless a later enacted statute that becomes operative on or before December 31, 2015, deletes or extends that date.

SEC. 7. Section 128225.5 of the Health and Safety Code is amended to read:

128225.5. (a) The commission shall review and make recommendations to the Director of the Office of Statewide Health Planning and Development concerning the provision of grants pursuant to this section. In making recommendations, the commission shall give priority to residency programs that demonstrate all of the following:

(1) That the grant will be used to support new primary care physician slots.

(2) That priority in filling the position shall be given to physicians who have graduated from a California-based medical school.

(3) That the new primary care physician residency positions have been, or will be, approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association prior to the first distribution of grant funds.

(b) The director shall do both of the following:

(1) Determine whether the residency programs recommended by the commission meet the standards established by this section.

(2) Select and contract on behalf of the state with accredited primary care or family medicine residency programs for the purpose of providing grants for the support of newly created residency positions.

(c) This section does not apply to funding appropriated in the annual Budget Act for the Song-Brown Health Care Workforce Training Act (Article 1 (commencing with Section 128200)).

(d) This section shall be operative only if funds are appropriated in the Budget Act of 2014 for the purposes described in this section.

(e) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

SEC. 8. Section 10961 of the Insurance Code is amended and renumbered to read:

10965.18. (a) For purposes of this chapter, a bridge plan product shall mean an individual health benefit plan that is offered by a health insurer licensed under this part that contracts with the Exchange pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(b) On and after September 30, 2013, if a health insurance policy has not been filed with the commissioner, a health insurer that contracts with the Exchange to offer a qualified bridge plan product

pursuant to Section 100504.5 of the Government Code shall file the policy form with the commissioner pursuant to Section 10290.

(c) (1) Notwithstanding subdivision (a) of Section 10965.3, a health insurer selling a bridge plan product shall not be required to fairly and affirmatively offer, market, and sell the health insurer's bridge plan product except to individuals eligible for the bridge plan product pursuant to the State Department of Health Care Services and the Medi-Cal managed care plan's contract entered into pursuant to Section 14005.70 of the Welfare and Institutions Code, provided the health care service plan meets the requirements of subdivision (b) of Section 14005.70 of the Welfare and Institutions Code.

(2) Notwithstanding subdivision (c) of Section 10965.3, a health insurer selling a bridge plan product shall provide an initial open enrollment period of six months, and an annual enrollment period and a special enrollment period consistent with the annual enrollment and special enrollment periods of the Exchange.

(d) A health insurer that contracts with the Exchange to offer a qualified bridge plan product pursuant to Section 100504.5 of the Government Code shall maintain a medical loss ratio of 85 percent for the bridge plan product. A health insurer shall utilize, to the extent possible, the same methodology for calculating the medical loss ratio for the bridge plan product that is used for calculating the health insurer's medical loss ratio pursuant to Section 10112.25 and shall report its medical loss ratio for the bridge plan product to the department as provided in Section 10112.25.

(e) This section shall become inoperative on the October 1 that is five years after the date that federal approval of the bridge plan option occurs, and, as of the second January 1 thereafter, is repealed, unless a later enacted statute that is enacted before that date deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 9. Section 308 of the Penal Code is amended to read:

308. (a) (1) Every person, firm, or corporation that knowingly or under circumstances in which it has knowledge, or should otherwise have grounds for knowledge, sells, gives, or in any way furnishes to another person who is under the age of 18 years any tobacco, cigarette, or cigarette papers, or blunts wraps, or any other preparation of tobacco, or any other instrument or paraphernalia that is designed for the smoking or ingestion of tobacco, products

prepared from tobacco, or any controlled substance, is subject to either a criminal action for a misdemeanor or to a civil action brought by a city attorney, a county counsel, or a district attorney, punishable by a fine of two hundred dollars ($200) for the first offense, five hundred dollars ($500) for the second offense, and one thousand dollars ($1,000) for the third offense.

Notwithstanding Section 1464 or any other law, 25 percent of each civil and criminal penalty collected pursuant to this subdivision shall be paid to the office of the city attorney, county counsel, or district attorney, whoever is responsible for bringing the successful action, and 25 percent of each civil and criminal penalty collected pursuant to this subdivision shall be paid to the city or county for the administration and cost of the community service work component provided in subdivision (b).

Proof that a defendant, or his or her employee or agent, demanded, was shown, and reasonably relied upon evidence of majority shall be defense to any action brought pursuant to this subdivision. Evidence of majority of a person is a facsimile of or a reasonable likeness of a document issued by a federal, state, county, or municipal government, or subdivision or agency thereof, including, but not limited to, a motor vehicle operator's license, a registration certificate issued under the federal Selective Service Act, or an identification card issued to a member of the Armed Forces.

For purposes of this section, the person liable for selling or furnishing tobacco products to minors by a tobacco vending machine shall be the person authorizing the installation or placement of the tobacco vending machine upon premises he or she manages or otherwise controls and under circumstances in which he or she has knowledge, or should otherwise have grounds for knowledge, that the tobacco vending machine will be utilized by minors.

(2) For purposes of this section, "blunt wraps" means cigar papers or cigar wrappers of all types that are designed for smoking or ingestion of tobacco products and contain less than 50 percent tobacco.

(b) Every person under the age of 18 years who purchases, receives, or possesses any tobacco, cigarette, or cigarette papers, or any other preparation of tobacco, or any other instrument or paraphernalia that is designed for the smoking of tobacco, products

prepared from tobacco, or any controlled substance shall, upon conviction, be punished by a fine of seventy-five dollars ($75) or 30 hours of community service work.

(c) Every person, firm, or corporation that sells, or deals in tobacco or any preparation thereof, shall post conspicuously and keep so posted in his, her, or their place of business at each point of purchase the notice required pursuant to subdivision (b) of Section 22952 of the Business and Professions Code, and any person failing to do so shall, upon conviction, be punished by a fine of fifty dollars ($50) for the first offense, one hundred dollars ($100) for the second offense, two hundred fifty dollars ($250) for the third offense, and five hundred dollars ($500) for the fourth offense and each subsequent violation of this provision, or by imprisonment in a county jail not exceeding 30 days.

(d) For purposes of determining the liability of persons, firms, or corporations controlling franchises or business operations in multiple locations for the second and subsequent violations of this section, each individual franchise or business location shall be deemed a separate entity.

(e) Notwithstanding subdivision (b), any person under 18 years of age who purchases, receives, or possesses any tobacco, cigarette, or cigarette papers, or any other preparation of tobacco, any other instrument or paraphernalia that is designed for the smoking of tobacco, or products prepared from tobacco is immune from prosecution for that purchase, receipt, or possession while participating in either of the following:

(1) An enforcement activity that complies with the guidelines adopted pursuant to subdivisions (c) and (d) of Section 22952 of the Business and Professions Code.

(2) An activity conducted by the State Department of Public Health, a local health department, or a law enforcement agency for the purpose of determining or evaluating youth tobacco purchase rates.

(f) It is the Legislature’s intent to regulate the subject matter of this section. As a result, a city, county, or city and county shall not adopt any ordinance or regulation inconsistent with this section.

SEC. 10. Section 667.5 of the Penal Code is amended to read:

667.5. Enhancement of prison terms for new offenses because of prior prison terms shall be imposed as follows:

(a) Where one of the new offenses is one of the violent felonies specified in subdivision (c), in addition to and consecutive to any other prison terms therefor, the court shall impose a three-year term for each prior separate prison term served by the defendant where the prior offense was one of the violent felonies specified in subdivision (c). However, no additional term shall be imposed under this subdivision for any prison term served prior to a period of 10 years in which the defendant remained free of both prison custody and the commission of an offense which results in a felony conviction.

(b) Except where subdivision (a) applies, where the new offense is any felony for which a prison sentence or a sentence of imprisonment in a county jail under subdivision (h) of Section 1170 is imposed or is not suspended, in addition and consecutive to any other sentence therefor, the court shall impose a one-year term for each prior separate prison term or county jail term imposed under subdivision (h) of Section 1170 or when sentence is not suspended for any felony; provided that no additional term shall be imposed under this subdivision for any prison term or county jail term imposed under subdivision (h) of Section 1170 or when sentence is not suspended prior to a period of five years in which the defendant remained free of both the commission of an offense which results in a felony conviction, and prison custody or the imposition of a term of jail custody imposed under subdivision (h) of Section 1170 or any felony sentence that is not suspended. A term imposed under the provisions of paragraph (5) of subdivision (h) of Section 1170, wherein a portion of the term is suspended by the court to allow mandatory supervision, shall qualify as a prior county jail term for the purposes of the one-year enhancement.

(c) For the purpose of this section, "violent felony" shall mean any of the following:

(1) Murder or voluntary manslaughter.

(2) Mayhem.

(3) Rape as defined in paragraph (2) or (6) of subdivision (a) of Section 261 or paragraph (1) or (4) of subdivision (a) of Section 262.

(4) Sodomy as defined in subdivision (c) or (d) of Section 286.

(5) Oral copulation as defined in subdivision (c) or (d) of Section 288a.

(6) Lewd or lascivious act as defined in subdivision (a) or (b) of Section 288.

(7) Any felony punishable by death or imprisonment in the state prison for life.

(8) Any felony in which the defendant inflicts great bodily injury on any person other than an accomplice which has been charged and proved as provided for in Section 12022.7, 12022.8, or 12022.9 on or after July 1, 1977, or as specified prior to July 1, 1977, in Sections 213, 264, and 461, or any felony in which the defendant uses a firearm which use has been charged and proved as provided in subdivision (a) of Section 12022.3, or Section 12022.5 or 12022.55.

(9) Any robbery.

(10) Arson, in violation of subdivision (a) or (b) of Section 451.

(11) Sexual penetration as defined in subdivision (a) or (j) of Section 289.

(12) Attempted murder.

(13) A violation of Section 18745, 18750, or 18755.

(14) Kidnapping.

(15) Assault with the intent to commit a specified felony, in violation of Section 220.

(16) Continuous sexual abuse of a child, in violation of Section 288.5.

(17) Carjacking, as defined in subdivision (a) of Section 215.

(18) Rape, spousal rape, or sexual penetration, in concert, in violation of Section 264.1.

(19) Extortion, as defined in Section 518, which would constitute a felony violation of Section 186.22.

(20) Threats to victims or witnesses, as defined in Section 136.1, which would constitute a felony violation of Section 186.22.

(21) Any burglary of the first degree, as defined in subdivision (a) of Section 460, wherein it is charged and proved that another person, other than an accomplice, was present in the residence during the commission of the burglary.

(22) Any violation of Section 12022.53.

(23) A violation of subdivision (b) or (c) of Section 11418. The Legislature finds and declares that these specified crimes merit special consideration when imposing a sentence to display society's condemnation for these extraordinary crimes of violence against the person.

(d) For the purposes of this section, the defendant shall be deemed to remain in prison custody for an offense until the official discharge from custody, including any period of mandatory supervision, or until release on parole or postrelease community supervision, whichever first occurs, including any time during which the defendant remains subject to reimprisonment or custody in county jail for escape from custody or is reimprisoned on revocation of parole or postrelease community supervision. The additional penalties provided for prior prison terms shall not be imposed unless they are charged and admitted or found true in the action for the new offense.

(e) The additional penalties provided for prior prison terms shall not be imposed for any felony for which the defendant did not serve a prior separate term in state prison or in county jail under subdivision (h) of Section 1170.

(f) A prior conviction of a felony shall include a conviction in another jurisdiction for an offense which, if committed in California, is punishable by imprisonment in the state prison or in county jail under subdivision (h) of Section 1170 if the defendant served one year or more in prison for the offense in the other jurisdiction. A prior conviction of a particular felony shall include a conviction in another jurisdiction for an offense which includes all of the elements of the particular felony as defined under California law if the defendant served one year or more in prison for the offense in the other jurisdiction.

(g) A prior separate prison term for the purposes of this section shall mean a continuous completed period of prison incarceration imposed for the particular offense alone or in combination with concurrent or consecutive sentences for other crimes, including any reimprisonment on revocation of parole which is not accompanied by a new commitment to prison, and including any reimprisonment after an escape from incarceration.

(h) Serving a prison term includes any confinement time in any state prison or federal penal institution as punishment for commission of an offense, including confinement in a hospital or other institution or facility credited as service of prison time in the jurisdiction of the confinement.

(i) For the purposes of this section, a commitment to the State Department of Mental Health, or its successor the State Department of State Hospitals, as a mentally disordered sex offender following

a conviction of a felony, which commitment exceeds one year in duration, shall be deemed a prior prison term.

(j) For the purposes of this section, when a person subject to the custody, control, and discipline of the Secretary of the Department of Corrections and Rehabilitation is incarcerated at a facility operated by the Division of Juvenile Justice, that incarceration shall be deemed to be a term served in state prison.

(k) (1) Notwithstanding subdivisions (d) and (g) or any other provision of law, where one of the new offenses is committed while the defendant is temporarily removed from prison pursuant to Section 2690 or while the defendant is transferred to a community facility pursuant to Section 3416, 6253, or 6263, or while the defendant is on furlough pursuant to Section 6254, the defendant shall be subject to the full enhancements provided for in this section.

(2) This subdivision shall not apply when a full, separate, and consecutive term is imposed pursuant to any other provision of law.

SEC. 11. Section 3000 of the Penal Code is amended to read:

3000. (a) (1) The Legislature finds and declares that the period immediately following incarceration is critical to successful reintegration of the offender into society and to positive citizenship. It is in the interest of public safety for the state to provide for the effective supervision of and surveillance of parolees, including the judicious use of revocation actions, and to provide educational, vocational, family, and personal counseling necessary to assist parolees in the transition between imprisonment and discharge. A sentence resulting in imprisonment in the state prison pursuant to Section 1168 or 1170 shall include a period of parole supervision or postrelease community supervision, unless waived, or as otherwise provided in this article.

(2) The Legislature finds and declares that it is not the intent of this section to diminish resources allocated to the Department of Corrections and Rehabilitation for parole functions for which the department is responsible. It is also not the intent of this section to diminish the resources allocated to the Board of Parole Hearings to execute its duties with respect to parole functions for which the board is responsible.

(3) The Legislature finds and declares that diligent effort must be made to ensure that parolees are held accountable for their

criminal behavior, including, but not limited to, the satisfaction of restitution fines and orders.

(4) For any person subject to a sexually violent predator proceeding pursuant to Article 4 (commencing with Section 6600) of Chapter 2 of Part 2 of Division 6 of the Welfare and Institutions Code, an order issued by a judge pursuant to Section 6601.5 of the Welfare and Institutions Code, finding that the petition, on its face, supports a finding of probable cause to believe that the individual named in the petition is likely to engage in sexually violent predatory criminal behavior upon his or her release, shall toll the period of parole of that person, from the date that person is released by the Department of Corrections and Rehabilitation as follows:

(A) If the person is committed to the State Department of State Hospitals as a sexually violent predator and subsequently a court orders that the person be unconditionally discharged, the parole period shall be tolled until the date the judge enters the order unconditionally discharging that person.

(B) If the person is not committed to the State Department of State Hospitals as a sexually violent predator, the tolling of the parole period shall be abrogated and the parole period shall be deemed to have commenced on the date of release from the Department of Corrections and Rehabilitation.

(5) Paragraph (4) applies to persons released by the Department of Corrections and Rehabilitation on or after January 1, 2012. Persons released by the Department of Corrections and Rehabilitation prior to January 1, 2012, shall continue to be subject to the law governing the tolling of parole in effect on December 31, 2011.

(b) Notwithstanding any provision to the contrary in Article 3 (commencing with Section 3040) of this chapter, the following shall apply to any inmate subject to Section 3000.08:

(1) In the case of any inmate sentenced under Section 1168 for a crime committed prior to July 1, 2013, the period of parole shall not exceed five years in the case of an inmate imprisoned for any offense other than first or second degree murder for which the inmate has received a life sentence, and shall not exceed three years in the case of any other inmate, unless in either case the Board of Parole Hearings for good cause waives parole and discharges the inmate from custody of the department. This subdivision shall also be applicable to inmates who committed

crimes prior to July 1, 1977, to the extent specified in Section 1170.2. In the case of any inmate sentenced under Section 1168 for a crime committed on or after July 1, 2013, the period of parole shall not exceed five years in the case of an inmate imprisoned for any offense other than first or second degree murder for which the inmate has received a life sentence, and shall not exceed three years in the case of any other inmate, unless in either case the department for good cause waives parole and discharges the inmate from custody of the department.

(2) (A) For a crime committed prior to July 1, 2013, at the expiration of a term of imprisonment of one year and one day, or a term of imprisonment imposed pursuant to Section 1170 or at the expiration of a term reduced pursuant to Section 2931 or 2933, if applicable, the inmate shall be released on parole for a period not exceeding three years, except that any inmate sentenced for an offense specified in paragraph (3), (4), (5), (6), (11), or (18) of subdivision (c) of Section 667.5 shall be released on parole for a period not exceeding 10 years, unless a longer period of parole is specified in Section 3000.1.

(B) For a crime committed on or after July 1, 2013, at the expiration of a term of imprisonment of one year and one day, or a term of imprisonment imposed pursuant to Section 1170 or at the expiration of a term reduced pursuant to Section 2931 or 2933, if applicable, the inmate shall be released on parole for a period of three years, except that any inmate sentenced for an offense specified in paragraph (3), (4), (5), (6), (11), or (18) of subdivision (c) of Section 667.5 shall be released on parole for a period of 10 years, unless a longer period of parole is specified in Section 3000.1.

(3) Notwithstanding paragraphs (1) and (2), in the case of any offense for which the inmate has received a life sentence pursuant to subdivision (b) of Section 209, with the intent to commit a specified sex offense, or Section 667.51, 667.61, or 667.71, the period of parole shall be 10 years, unless a longer period of parole is specified in Section 3000.1.

(4) (A) Notwithstanding paragraphs (1) to (3), inclusive, in the case of a person convicted of and required to register as a sex offender for the commission of an offense specified in Section 261, 262, 264.1, 286, 288a, paragraph (1) of subdivision (b) of Section 288, Section 288.5, or 289, in which one or more of the

victims of the offense was a child under 14 years of age, the period of parole shall be 20 years and six months unless the board, for good cause, determines that the person will be retained on parole. The board shall make a written record of this determination and transmit a copy of it to the parolee.

(B) In the event of a retention on parole, the parolee shall be entitled to a review by the board each year thereafter.

(C) There shall be a board hearing consistent with the procedures set forth in Sections 3041.5 and 3041.7 within 12 months of the date of any revocation of parole to consider the release of the inmate on parole, and notwithstanding the provisions of paragraph (3) of subdivision (b) of Section 3041.5, there shall be annual parole consideration hearings thereafter, unless the person is released or otherwise ineligible for parole release. The panel or board shall release the person within one year of the date of the revocation unless it determines that the circumstances and gravity of the parole violation are such that consideration of the public safety requires a more lengthy period of incarceration or unless there is a new prison commitment following a conviction.

(D) The provisions of Section 3042 shall not apply to any hearing held pursuant to this subdivision.

(5) (A) The Board of Parole Hearings shall consider the request of any inmate whose commitment offense occurred prior to July 1, 2013, regarding the length of his or her parole and the conditions thereof.

(B) For an inmate whose commitment offense occurred on or after July 1, 2013, except for those inmates described in Section 3000.1, the department shall consider the request of the inmate regarding the length of his or her parole and the conditions thereof. For those inmates described in Section 3000.1, the Board of Parole Hearings shall consider the request of the inmate regarding the length of his or her parole and the conditions thereof.

(6) Upon successful completion of parole, or at the end of the maximum statutory period of parole specified for the inmate under paragraph (1), (2), (3), or (4), as the case may be, whichever is earlier, the inmate shall be discharged from custody. The date of the maximum statutory period of parole under this subdivision and paragraphs (1), (2), (3), and (4) shall be computed from the date of initial parole and shall be a period chronologically determined. Time during which parole is suspended because the prisoner has

absconded or has been returned to custody as a parole violator shall not be credited toward any period of parole unless the prisoner is found not guilty of the parole violation. However, the period of parole is subject to the following:

(A) Except as provided in Section 3064, in no case may a prisoner subject to three years on parole be retained under parole supervision or in custody for a period longer than four years from the date of his or her initial parole.

(B) Except as provided in Section 3064, in no case may a prisoner subject to five years on parole be retained under parole supervision or in custody for a period longer than seven years from the date of his or her initial parole.

(C) Except as provided in Section 3064, in no case may a prisoner subject to 10 years on parole be retained under parole supervision or in custody for a period longer than 15 years from the date of his or her initial parole.

(7) The Department of Corrections and Rehabilitation shall meet with each inmate at least 30 days prior to his or her good time release date and shall provide, under guidelines specified by the parole authority or the department, whichever is applicable, the conditions of parole and the length of parole up to the maximum period of time provided by law. The inmate has the right to reconsideration of the length of parole and conditions thereof by the department or the parole authority, whichever is applicable. The Department of Corrections and Rehabilitation or the board may impose as a condition of parole that a prisoner make payments on the prisoner's outstanding restitution fines or orders imposed pursuant to subdivision (a) or (c) of Section 13967 of the Government Code, as operative prior to September 28, 1994, or subdivision (b) or (f) of Section 1202.4.

(8) For purposes of this chapter, and except as otherwise described in this section, the board shall be considered the parole authority.

(9) (A) On and after July 1, 2013, the sole authority to issue warrants for the return to actual custody of any state prisoner released on parole rests with the court pursuant to Section 1203.2, except for any escaped state prisoner or any state prisoner released prior to his or her scheduled release date who should be returned to custody, and Section 5054.1 shall apply.

(B) Notwithstanding subparagraph (A), any warrant issued by the Board of Parole Hearings prior to July 1, 2013, shall remain in full force and effect until the warrant is served or it is recalled by the board. All prisoners on parole arrested pursuant to a warrant issued by the board shall be subject to a review by the board prior to the department filing a petition with the court to revoke the parole of the petitioner.

(10) It is the intent of the Legislature that efforts be made with respect to persons who are subject to Section 290.011 who are on parole to engage them in treatment.

SEC. 12. Section 2356 of the Probate Code is amended to read:

2356. (a) No ward or conservatee may be placed in a mental health treatment facility under this division against the will of the ward or conservatee. Involuntary civil placement of a ward or conservatee in a mental health treatment facility may be obtained only pursuant to Chapter 2 (commencing with Section 5150) or Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code. Nothing in this subdivision precludes the placing of a ward in a state hospital under Section 6000 of the Welfare and Institutions Code upon application of the guardian as provided in that section. The Director of State Hospitals shall adopt and issue regulations defining "mental health treatment facility" for the purposes of this subdivision.

(b) No experimental drug as defined in Section 111515 of the Health and Safety Code may be prescribed for or administered to a ward or conservatee under this division. Such an experimental drug may be prescribed for or administered to a ward or conservatee only as provided in Article 4 (commencing with Section 111515) of Chapter 6 of Part 5 of Division 104 of the Health and Safety Code.

(c) No convulsive treatment as defined in Section 5325 of the Welfare and Institutions Code may be performed on a ward or conservatee under this division. Convulsive treatment may be performed on a ward or conservatee only as provided in Article 7 (commencing with Section 5325) of Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code.

(d) No minor may be sterilized under this division.

(e) This chapter is subject to a valid and effective advance health care directive under the Health Care Decisions Law (Division 4.7 (commencing with Section 4600)).

SEC. 13. Section 736 of the Welfare and Institutions Code is amended to read:

736. (a) Except as provided in Section 733, the Department of Corrections and Rehabilitation, Division of Juvenile Facilities, shall accept a ward committed to it pursuant to this article if the Director of the Division of Juvenile Justice believes that the ward can be materially benefited by the division's reformatory and educational discipline, and if the division has adequate facilities, staff, and programs to provide that care. A ward subject to this section shall not be transported to any facility under the jurisdiction of the division until the superintendent of the facility has notified the committing court of the place to which that ward is to be transported and the time at which he or she can be received.

(b) To determine who is best served by the Division of Juvenile Facilities, and who would be better served by the State Department of State Hospitals, the Director of the Division of Juvenile Justice and the Director of State Hospitals shall, at least annually, confer and establish policy with respect to the types of cases that should be the responsibility of each department.

SEC. 14. Section 5328.15 of the Welfare and Institutions Code is amended to read:

5328.15. All information and records obtained in the course of providing services under Division 5 (commencing with Section 5000), Division 6 (commencing with Section 6000), or Division 7 (commencing with Section 7000), to either voluntary or involuntary recipients of services shall be confidential. Information and records may be disclosed, however, notwithstanding any other provision of law, as follows:

(a) To authorized licensing personnel who are employed by, or who are authorized representatives of, the State Department of Public Health, and who are licensed or registered health professionals, and to authorized legal staff or special investigators who are peace officers who are employed by, or who are authorized representatives of the State Department of Social Services, as necessary to the performance of their duties to inspect, license, and investigate health facilities and community care facilities and to ensure that the standards of care and services provided in such facilities are adequate and appropriate and to ascertain compliance with the rules and regulations to which the facility is subject. The confidential information shall remain confidential except for

purposes of inspection, licensing, or investigation pursuant to Chapter 2 (commencing with Section 1250) of, and Chapter 3 (commencing with Section 1500) of, Division 2 of the Health and Safety Code, or a criminal, civil, or administrative proceeding in relation thereto. The confidential information may be used by the State Department of Public Health or the State Department of Social Services in a criminal, civil, or administrative proceeding. The confidential information shall be available only to the judge or hearing officer and to the parties to the case. Names which are confidential shall be listed in attachments separate to the general pleadings. The confidential information shall be sealed after the conclusion of the criminal, civil, or administrative hearings, and shall not subsequently be released except in accordance with this subdivision. If the confidential information does not result in a criminal, civil, or administrative proceeding, it shall be sealed after the State Department of Public Health or the State Department of Social Services decides that no further action will be taken in the matter of suspected licensing violations. Except as otherwise provided in this subdivision, confidential information in the possession of the State Department of Public Health or the State Department of Social Services shall not contain the name of the patient.

(b) To any board which licenses and certifies professionals in the fields of mental health pursuant to state law, when the Director of State Hospitals has reasonable cause to believe that there has occurred a violation of any provision of law subject to the jurisdiction of that board and the records are relevant to the violation. This information shall be sealed after a decision is reached in the matter of the suspected violation, and shall not subsequently be released except in accordance with this subdivision. Confidential information in the possession of the board shall not contain the name of the patient.

(c) To a protection and advocacy agency established pursuant to Section 4901, to the extent that the information is incorporated within any of the following:

(1) An unredacted facility evaluation report form or an unredacted complaint investigation report form of the State Department of Social Services. This information shall remain confidential and subject to the confidentiality requirements of subdivision (f) of Section 4903.

(2) An unredacted citation report, unredacted licensing report, unredacted survey report, unredacted plan of correction, or unredacted statement of deficiency of the State Department of Public Health, prepared by authorized licensing personnel or authorized representatives described in subdivision (n). This information shall remain confidential and subject to the confidentiality requirements of subdivision (f) of Section 4903.

SEC. 15. Section 6600 of the Welfare and Institutions Code is amended to read:

6600. As used in this article, the following terms have the following meanings:

(a) (1) "Sexually violent predator" means a person who has been convicted of a sexually violent offense against one or more victims and who has a diagnosed mental disorder that makes the person a danger to the health and safety of others in that it is likely that he or she will engage in sexually violent criminal behavior.

(2) For purposes of this subdivision any of the following shall be considered a conviction for a sexually violent offense:

(A) A prior or current conviction that resulted in a determinate prison sentence for an offense described in subdivision (b).

(B) A conviction for an offense described in subdivision (b) that was committed prior to July 1, 1977, and that resulted in an indeterminate prison sentence.

(C) A prior conviction in another jurisdiction for an offense that includes all of the elements of an offense described in subdivision (b).

(D) A conviction for an offense under a predecessor statute that includes all of the elements of an offense described in subdivision (b).

(E) A prior conviction for which the inmate received a grant of probation for an offense described in subdivision (b).

(F) A prior finding of not guilty by reason of insanity for an offense described in subdivision (b).

(G) A conviction resulting in a finding that the person was a mentally disordered sex offender.

(H) A prior conviction for an offense described in subdivision (b) for which the person was committed to the Division of Juvenile Facilities, Department of Corrections and Rehabilitation pursuant to Section 1731.5.

(I) A prior conviction for an offense described in subdivision (b) that resulted in an indeterminate prison sentence.

(3) Conviction of one or more of the crimes enumerated in this section shall constitute evidence that may support a court or jury determination that a person is a sexually violent predator, but shall not be the sole basis for the determination. The existence of any prior convictions may be shown with documentary evidence. The details underlying the commission of an offense that led to a prior conviction, including a predatory relationship with the victim, may be shown by documentary evidence, including, but not limited to, preliminary hearing transcripts, trial transcripts, probation and sentencing reports, and evaluations by the State Department of State Hospitals. Jurors shall be admonished that they may not find a person a sexually violent predator based on prior offenses absent relevant evidence of a currently diagnosed mental disorder that makes the person a danger to the health and safety of others in that it is likely that he or she will engage in sexually violent criminal behavior.

(4) The provisions of this section shall apply to any person against whom proceedings were initiated for commitment as a sexually violent predator on or after January 1, 1996.

(b) "Sexually violent offense" means the following acts when committed by force, violence, duress, menace, fear of immediate and unlawful bodily injury on the victim or another person, or threatening to retaliate in the future against the victim or any other person, and that are committed on, before, or after the effective date of this article and result in a conviction or a finding of not guilty by reason of insanity, as defined in subdivision (a): a felony violation of Section 261, 262, 264.1, 269, 286, 288, 288a, 288.5, or 289 of the Penal Code, or any felony violation of Section 207, 209, or 220 of the Penal Code, committed with the intent to commit a violation of Section 261, 262, 264.1, 286, 288, 288a, or 289 of the Penal Code.

(c) "Diagnosed mental disorder" includes a congenital or acquired condition affecting the emotional or volitional capacity that predisposes the person to the commission of criminal sexual acts in a degree constituting the person a menace to the health and safety of others.

(d) "Danger to the health and safety of others" does not require proof of a recent overt act while the offender is in custody.

(e) "Predatory" means an act is directed toward a stranger, a person of casual acquaintance with whom no substantial relationship exists, or an individual with whom a relationship has been established or promoted for the primary purpose of victimization.

(f) "Recent overt act" means any criminal act that manifests a likelihood that the actor may engage in sexually violent predatory criminal behavior.

(g) Notwithstanding any other provision of law and for purposes of this section, a prior juvenile adjudication of a sexually violent offense may constitute a prior conviction for which the person received a determinate term if all of the following apply:

(1) The juvenile was 16 years of age or older at the time he or she committed the prior offense.

(2) The prior offense is a sexually violent offense as specified in subdivision (b).

(3) The juvenile was adjudged a ward of the juvenile court within the meaning of Section 602 because of the person's commission of the offense giving rise to the juvenile court adjudication.

(4) The juvenile was committed to the Division of Juvenile Facilities, Department of Corrections and Rehabilitation for the sexually violent offense.

(h) A minor adjudged a ward of the court for commission of an offense that is defined as a sexually violent offense shall be entitled to specific treatment as a sexual offender. The failure of a minor to receive that treatment shall not constitute a defense or bar to a determination that any person is a sexually violent predator within the meaning of this article.

SEC. 16. Section 6601 of the Welfare and Institutions Code is amended to read:

6601. (a) (1) Whenever the Secretary of the Department of Corrections and Rehabilitation determines that an individual who is in custody under the jurisdiction of the Department of Corrections and Rehabilitation, and who is either serving a determinate prison sentence or whose parole has been revoked, may be a sexually violent predator, the secretary shall, at least six months prior to that individual's scheduled date for release from prison, refer the person for evaluation in accordance with this section. However, if the inmate was received by the department

with less than nine months of his or her sentence to serve, or if the inmate's release date is modified by judicial or administrative action, the secretary may refer the person for evaluation in accordance with this section at a date that is less than six months prior to the inmate's scheduled release date.

(2) A petition may be filed under this section if the individual was in custody pursuant to his or her determinate prison term, parole revocation term, or a hold placed pursuant to Section 6601.3, at the time the petition is filed. A petition shall not be dismissed on the basis of a later judicial or administrative determination that the individual's custody was unlawful, if the unlawful custody was the result of a good faith mistake of fact or law. This paragraph shall apply to any petition filed on or after January 1, 1996.

(b) The person shall be screened by the Department of Corrections and Rehabilitation and the Board of Parole Hearings based on whether the person has committed a sexually violent predatory offense and on a review of the person's social, criminal, and institutional history. This screening shall be conducted in accordance with a structured screening instrument developed and updated by the State Department of State Hospitals in consultation with the Department of Corrections and Rehabilitation. If as a result of this screening it is determined that the person is likely to be a sexually violent predator, the Department of Corrections and Rehabilitation shall refer the person to the State Department of State Hospitals for a full evaluation of whether the person meets the criteria in Section 6600.

(c) The State Department of State Hospitals shall evaluate the person in accordance with a standardized assessment protocol, developed and updated by the State Department of State Hospitals, to determine whether the person is a sexually violent predator as defined in this article. The standardized assessment protocol shall require assessment of diagnosable mental disorders, as well as various factors known to be associated with the risk of reoffense among sex offenders. Risk factors to be considered shall include criminal and psychosexual history, type, degree, and duration of sexual deviance, and severity of mental disorder.

(d) Pursuant to subdivision (c), the person shall be evaluated by two practicing psychiatrists or psychologists, or one practicing psychiatrist and one practicing psychologist, designated by the Director of State Hospitals. If both evaluators concur that the

person has a diagnosed mental disorder so that he or she is likely to engage in acts of sexual violence without appropriate treatment and custody, the Director of State Hospitals shall forward a request for a petition for commitment under Section 6602 to the county designated in subdivision (i). Copies of the evaluation reports and any other supporting documents shall be made available to the attorney designated by the county pursuant to subdivision (i) who may file a petition for commitment.

(e) If one of the professionals performing the evaluation pursuant to subdivision (d) does not concur that the person meets the criteria specified in subdivision (d), but the other professional concludes that the person meets those criteria, the Director of State Hospitals shall arrange for further examination of the person by two independent professionals selected in accordance with subdivision (g).

(f) If an examination by independent professionals pursuant to subdivision (e) is conducted, a petition to request commitment under this article shall only be filed if both independent professionals who evaluate the person pursuant to subdivision (e) concur that the person meets the criteria for commitment specified in subdivision (d). The professionals selected to evaluate the person pursuant to subdivision (g) shall inform the person that the purpose of their examination is not treatment but to determine if the person meets certain criteria to be involuntarily committed pursuant to this article. It is not required that the person appreciate or understand that information.

(g) Any independent professional who is designated by the Secretary of the Department of Corrections and Rehabilitation or the Director of State Hospitals for purposes of this section shall not be a state government employee, shall have at least five years of experience in the diagnosis and treatment of mental disorders, and shall include psychiatrists and licensed psychologists who have a doctoral degree in psychology. The requirements set forth in this section also shall apply to any professionals appointed by the court to evaluate the person for purposes of any other proceedings under this article.

(h) If the State Department of State Hospitals determines that the person is a sexually violent predator as defined in this article, the Director of State Hospitals shall forward a request for a petition to be filed for commitment under this article to the county

designated in subdivision (i). Copies of the evaluation reports and any other supporting documents shall be made available to the attorney designated by the county pursuant to subdivision (i) who may file a petition for commitment in the superior court.

(i) If the county's designated counsel concurs with the recommendation, a petition for commitment shall be filed in the superior court of the county in which the person was convicted of the offense for which he or she was committed to the jurisdiction of the Department of Corrections and Rehabilitation. The petition shall be filed, and the proceedings shall be handled, by either the district attorney or the county counsel of that county. The county board of supervisors shall designate either the district attorney or the county counsel to assume responsibility for proceedings under this article.

(j) The time limits set forth in this section shall not apply during the first year that this article is operative.

(k) An order issued by a judge pursuant to Section 6601.5, finding that the petition, on its face, supports a finding of probable cause to believe that the individual named in the petition is likely to engage in sexually violent predatory criminal behavior upon his or her release, shall toll that person's parole pursuant to paragraph (4) of subdivision (a) of Section 3000 of the Penal Code, if that individual is determined to be a sexually violent predator.

(*l*) Pursuant to subdivision (d), the attorney designated by the county pursuant to subdivision (i) shall notify the State Department of State Hospitals of its decision regarding the filing of a petition for commitment within 15 days of making that decision.

(m) This section shall become operative on the date that the director executes a declaration, which shall be provided to the fiscal and policy committees of the Legislature, including the Chairperson of the Joint Legislative Budget Committee, and the Department of Finance, specifying that sufficient qualified state employees have been hired to conduct the evaluations required pursuant to subdivision (d), or January 1, 2013, whichever occurs first.

SEC. 17. Section 6608.7 of the Welfare and Institutions Code is amended to read:

6608.7. The State Department of State Hospitals may enter into an interagency agreement or contract with the Department of Corrections and Rehabilitation or with local law enforcement

agencies for services related to supervision or monitoring of sexually violent predators who have been conditionally released into the community under the forensic conditional release program pursuant to this article.

SEC. 18. Section 6609 of the Welfare and Institutions Code is amended to read:

6609. Within 10 days of a request made by the chief of police of a city or the sheriff of a county, the State Department of State Hospitals shall provide the following information concerning each person committed as a sexually violent predator who is receiving outpatient care in a conditional release program in that city or county: name, address, date of commitment, county from which committed, date of placement in the conditional release program, fingerprints, and a glossy photograph no smaller than $3\frac{1}{8} \times 3\frac{1}{8}$ inches in size, or clear copies of the fingerprints and photograph.

SEC. 19. Section 9717 of the Welfare and Institutions Code is amended to read:

9717. (a) All advocacy programs and any programs similar in nature to the Long-Term Care Ombudsman Program that receive funding or official designation from the state shall cooperate with the office, where appropriate. These programs include, but are not limited to, the Office of Human Rights within the State Department of State Hospitals, the Office of Patients' Rights, Disability Rights California, and the Department of Rehabilitation's Client Assistance Program.

(b) The office shall maintain a close working relationship with the Legal Services Development Program for the Elderly within the department.

(c) In order to ensure the provision of counsel for patients and residents of long-term care facilities, the office shall seek to establish effective coordination with programs that provide legal services for the elderly, including, but not limited to, programs that are funded by the federal Legal Services Corporation or under the federal Older Americans Act (42 U.S.C. Sec. 3001 et seq.), as amended.

(d) The department and other state departments and programs that have roles in funding, regulating, monitoring, or serving long-term care facility residents, including law enforcement agencies, shall cooperate with and meet with the office periodically and as needed to address concerns or questions involving the care,

quality of life, safety, rights, health, and well-being of long-term care facility residents.

SEC. 20. Section 10600.1 of the Welfare and Institutions Code is amended to read:

10600.1. (a) The State Department of Social Services succeeds to and is vested with the duties, purposes, responsibilities, and jurisdiction exercised by the State Department of Health or the State Department of Benefit Payments pursuant to the provisions of this division, except those contained in Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), Chapter 8.5 (commencing with Section 14500), and Chapter 8.7 (commencing with Section 14520) of Part 3, on the date immediately prior to the date this section becomes operative.

(b) The State Department of Social Services also succeeds to and is vested with the duties, purposes, responsibilities, and jurisdiction heretofore exercised by the State Department of Health with respect to its disability determination function performed pursuant to Titles II and XVI of the federal Social Security Act; provided, however, that this paragraph shall not vest in the State Department of Social Services any power or authority over programs for aid or rehabilitation of mentally disordered or developmentally disabled persons administered by the State Department of State Hospitals or the State Department of Developmental Services.

SEC. 21. Section 10725 of the Welfare and Institutions Code is amended to read:

10725. The director may adopt regulations, orders, or standards of general application to implement, interpret, or make specific the law enforced by the department, and those regulations, orders, and standards shall be adopted, amended, or repealed by the director only in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Regulations relating to services need not be printed in the California Code of Regulations or the California Regulatory Notice Register if they are included in the publications of the department. This authority also may be exercised by the director's designee.

In adopting regulations the director shall strive for clarity of language that may be readily understood by those administering services or subject to those regulations.

The rules of the department need not specify or include the detail of forms, reports, or records, but shall include the essential authority by which any person, agency, organization, association, or institution subject to the supervision or investigation of the department is required to use, submit, or maintain those forms, reports, or records.

SEC. 22. Section 14043.26 of the Welfare and Institutions Code is amended to read:

14043.26. (a) (1) On and after January 1, 2004, an applicant that currently is not enrolled in the Medi-Cal program, or a provider applying for continued enrollment, upon written notification from the department that enrollment for continued participation of all providers in a specific provider of service category or subgroup of that category to which the provider belongs will occur, or, except as provided in subdivisions (b) and (e), a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, shall submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location.

(2) Clinics licensed by the department pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(3) Health facilities licensed by the department pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(4) Adult day health care providers licensed pursuant to Chapter 3.3 (commencing with Section 1570) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(5) Home health agencies licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(6) Hospices licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code

and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(b) A physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California, or a dentist licensed by the Dental Board of California, practicing as an individual physician practice or as an individual dentist practice, as defined in Section 14043.1, who is enrolled and in good standing in the Medi-Cal program, and who is changing locations of that individual physician practice or individual dentist practice within the same county, shall be eligible to continue enrollment at the new location by filing a change of location form to be developed by the department. The form shall comply with all minimum federal requirements related to Medicaid provider enrollment. Filing this form shall be in lieu of submitting a complete application package pursuant to subdivision (a).

(c) (1) Except as provided in paragraph (2), within 30 days after receiving an application package submitted pursuant to subdivision (a), the department shall provide written notice that the application package has been received and, if applicable, that there is a moratorium on the enrollment of providers in the specific provider of service category or subgroup of the category to which the applicant or provider belongs. This moratorium shall bar further processing of the application package.

(2) Within 15 days after receiving an application package from a physician, or a group of physicians, licensed by the Medical Board of California or the Osteopathic Medical Board of California, or a change of location form pursuant to subdivision (b), the department shall provide written notice that the application package or the change of location form has been received.

(d) (1) If the application package submitted pursuant to subdivision (a) is from an applicant or provider who meets the criteria listed in paragraph (2), the applicant or provider shall be considered a preferred provider and shall be granted preferred provisional provider status pursuant to this section and for a period of no longer than 18 months, effective from the date on the notice from the department. The ability to request consideration as a preferred provider and the criteria necessary for the consideration shall be publicized to all applicants and providers. An applicant or provider who desires consideration as a preferred provider pursuant to this subdivision shall request consideration from the

department by making a notation to that effect on the application package, by cover letter, or by other means identified by the department in a provider bulletin. Request for consideration as a preferred provider shall be made with each application package submitted in order for the department to grant the consideration. An applicant or provider who requests consideration as a preferred provider shall be notified within 60 days whether the applicant or provider meets or does not meet the criteria listed in paragraph (2). If an applicant or provider is notified that the applicant or provider does not meet the criteria for a preferred provider, the application package submitted shall be processed in accordance with the remainder of this section.

(2) To be considered a preferred provider, the applicant or provider shall meet all of the following criteria:

(A) Hold a current license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California, which license shall not have been revoked, whether stayed or not, suspended, placed on probation, or subject to other limitation.

(B) Be a current faculty member of a teaching hospital or a children's hospital, as defined in Section 10727, accredited by the Joint Commission or the American Osteopathic Association, or be credentialed by a health care service plan that is licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) or county organized health system, or be a current member in good standing of a group that is credentialed by a health care service plan that is licensed under the Knox-Keene Act.

(C) Have full, current, unrevoked, and unsuspended privileges at a Joint Commission or American Osteopathic Association accredited general acute care hospital.

(D) Not have any adverse entries in the federal Healthcare Integrity and Protection Data Bank.

(3) The department may recognize other providers as qualifying as preferred providers if criteria similar to those set forth in paragraph (2) are identified for the other providers. The department shall consult with interested parties and appropriate stakeholders to identify similar criteria for other providers so that they may be considered as preferred providers.

(e) (1) If a Medi-Cal applicant meets the criteria listed in paragraph (2), the applicant shall be enrolled in the Medi-Cal program after submission and review of a short form application to be developed by the department. The form shall comply with all minimum federal requirements related to Medicaid provider enrollment. The department shall notify the applicant that the department has received the application within 15 days of receipt of the application. The department shall enroll the applicant or notify the applicant that the applicant does not meet the criteria listed in paragraph (2) within 90 days of receipt of the application.

(2) Notwithstanding any other provision of law, an applicant or provider who meets all of the following criteria shall be eligible for enrollment in the Medi-Cal program pursuant to this subdivision, after submission and review of a short form application:

(A) The applicant's or provider's practice is based in one or more of the following: a general acute care hospital, a rural general acute care hospital, or an acute psychiatric hospital, as defined in subdivisions (a) and (b) of Section 1250 of the Health and Safety Code.

(B) The applicant or provider holds a current, unrevoked, or unsuspended license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California. An applicant or provider shall not be in compliance with this subparagraph if a license revocation has been stayed, the licensee has been placed on probation, or the license is subject to any other limitation.

(C) The applicant or provider does not have an adverse entry in the federal Healthcare Integrity and Protection Data Bank.

(3) An applicant shall be granted provisional provider status under this subdivision for a period of 12 months.

(f) Except as provided in subdivision (g), within 180 days after receiving an application package submitted pursuant to subdivision (a), or from the date of the notice to an applicant or provider that the applicant or provider does not qualify as a preferred provider under subdivision (d), the department shall give written notice to the applicant or provider that any of the following applies, or shall on the 181st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 181st day:

(1) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(2) The application package is incomplete. The notice shall identify additional information or documentation that is needed to complete the application package.

(3) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7, and is conducting background checks, preenrollment inspections, or unannounced visits.

(4) The application package is denied for any of the following reasons:

(A) Pursuant to Section 14043.2 or 14043.36.

(B) For lack of a license necessary to perform the health care services or to provide the goods, supplies, or merchandise directly or indirectly to a Medi-Cal beneficiary, within the applicable provider of service category or subgroup of that category.

(C) The period of time during which an applicant or provider has been barred from reapplying has not passed.

(D) For other stated reasons authorized by law.

(E) For failing to submit fingerprints as required by federal Medicaid regulations.

(F) For failing to pay an application fee as required by federal Medicaid regulations.

(5) The application package is withdrawn by request of the applicant or provider and the department's review is canceled pursuant to subdivision (n).

(g) Notwithstanding subdivision (f), within 90 days after receiving an application package submitted pursuant to subdivision (a) from a physician or physician group licensed by the Medical Board of California or the Osteopathic Medical Board of California, or from the date of the notice to that physician or physician group that does not qualify as a preferred provider under subdivision (d), or within 90 days after receiving a change of location form submitted pursuant to subdivision (b), the department shall give written notice to the applicant or provider that either paragraph (1), (2), (3), (4), or (5) of subdivision (f) applies, or shall on the 91st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 91st day.

(h) (1) If the application package that was noticed as incomplete under paragraph (2) of subdivision (f) is resubmitted with all requested information and documentation, and received by the department within 60 days of the date on the notice, the department shall, within 60 days of the resubmission, send a notice that any of the following applies:

(A) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) The application package is denied for any other reasons provided for in paragraph (4) of subdivision (f).

(C) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits.

(D) The application package is withdrawn by request of the applicant or provider and the department's review is canceled pursuant to subdivision (n).

(2) (A) If the application package that was noticed as incomplete under paragraph (2) of subdivision (f) is not resubmitted with all requested information and documentation and received by the department within 60 days of the date on the notice, the application package shall be denied by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to resubmit is by a currently enrolled provider as defined in Section 14043.1, including providers applying for continued enrollment, the failure may make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the notice of an incomplete application package included a request for information or documentation related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider shall not reapply for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years.

(i) (1) If the department exercises its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks,

preenrollment inspections, or unannounced visits, the applicant or provider shall receive notice, from the department, after the conclusion of the background check, preenrollment inspection, or unannounced visit of either of the following:

(A) The applicant or provider is granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) Discrepancies or failure to meet program requirements, as prescribed by the department, have been found to exist during the preenrollment period.

(2) (A) The notice shall identify the discrepancies or failures, and whether remediation can be made or not, and if so, the time period within which remediation must be accomplished. Failure to remediate discrepancies and failures as prescribed by the department, or notification that remediation is not available, shall result in denial of the application by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to remediate is by a currently enrolled provider as defined in Section 14043.1, including providers applying for continued enrollment, the failure may make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the discrepancies or failure to meet program requirements, as prescribed by the director, included in the notice were related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider shall not reapply for three years.

(j) If provisional provider status or preferred provisional provider status is granted pursuant to this section, a provider number shall be used by the provider for each business address for which an application package has been approved. This provider number shall be used exclusively for the locations for which it was approved, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods, supplies, or merchandise are rendered or delivered at locations other than the provider's business address and this practice or delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the

department when the provisional provider status or preferred provisional provider status was granted.

(k) Except for providers subject to subdivision (c) of Section 14043.47, a provider currently enrolled in the Medi-Cal program at one or more locations who has submitted an application package for enrollment at a new location or a change in location pursuant to subdivision (a), or filed a change of location form pursuant to subdivision (b), may submit claims for services, goods, supplies, or merchandise rendered at the new location until the application package or change of location form is approved or denied under this section, and shall not be subject, during that period, to deactivation, or be subject to any delay or nonpayment of claims as a result of billing for services rendered at the new location as herein authorized. However, the provider shall be considered during that period to have been granted provisional provider status or preferred provisional provider status and be subject to termination of that status pursuant to Section 14043.27. A provider that is subject to subdivision (c) of Section 14043.47 may come within the scope of this subdivision upon submitting documentation in the application package that identifies the physician providing supervision for every three locations. If a provider submits claims for services rendered at a new location before the application for that location is received by the department, the department may deny the claim.

(*l*) An applicant or a provider whose application for enrollment, continued enrollment, or a new location or change in location has been denied pursuant to this section, may appeal the denial in accordance with Section 14043.65.

(m) (1) Upon receipt of a complete and accurate claim for an individual nurse provider, the department shall adjudicate the claim within an average of 30 days.

(2) During the budget proceedings of the 2006–07 fiscal year, and each fiscal year thereafter, the department shall provide data to the Legislature specifying the timeframe under which it has processed and approved the provider applications submitted by individual nurse providers.

(3) For purposes of this subdivision, "individual nurse providers" are providers authorized under certain home- and community-based waivers and under the state plan to provide nursing services to

Medi-Cal recipients in the recipients' own homes rather than in institutional settings.

(n) (1) Except as provided in paragraph (2), an applicant or provider may request to withdraw an application package submitted pursuant to this section at any time, at which point the department's review shall be canceled.

(2) The department's review shall not be canceled if, at the time the applicant or provider requests to withdraw the application package, the department has already initiated its review under Section 14043.37, 14043.4, or 14043.7.

SEC. 23. Section 14087.36 of the Welfare and Institutions Code is amended to read:

14087.36. (a) The following definitions shall apply for purposes of this section:

(1) "County" means the City and County of San Francisco.

(2) "Board" means the Board of Supervisors of the City and County of San Francisco.

(3) "Department" means the State Department of Health Care Services.

(4) "Governing body" means the governing body of the health authority.

(5) "Health authority" means the separate public agency established by the board of supervisors to operate a health care system in the county and to engage in the other activities authorized by this section.

(b) The Legislature finds and declares that it is necessary that a health authority be established in the county to arrange for the provision of health care services in order to meet the problems of the delivery of publicly assisted medical care in the county, to enter into a contract with the department under Article 2.97 (commencing with Section 14093), or to contract with a health care service plan on terms and conditions acceptable to the department, and to demonstrate ways of promoting quality care and cost efficiency.

(c) The county may, by resolution or ordinance, establish a health authority to act as and be the local initiative component of the Medi-Cal state plan pursuant to regulations adopted by the department. If the board elects to establish a health authority, all rights, powers, duties, privileges, and immunities vested in a county under Article 2.8 (commencing with Section 14087.5) and Article

2.97 (commencing with Section 14093) shall be vested in the health authority. The health authority shall have all power necessary and appropriate to operate programs involving health care services, including, but not limited to, the power to acquire, possess, and dispose of real or personal property, to employ personnel and contract for services required to meet its obligations, to sue or be sued, to take all actions and engage in all public and private business activities, subject to any applicable licensure, as permitted a health care service plan pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and to enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code.

(d) (1) (A) The health authority shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, separate and distinct from the county, and shall file the statement required by Section 53051 of the Government Code. The health authority shall have primary responsibility to provide the defense and indemnification required under Division 3.6 (commencing with Section 810) of Title 1 of the Government Code for employees of the health authority who are employees of the county. The health authority shall provide insurance under terms and conditions required by the county in order to satisfy its obligations under this section.

(B) For purposes of this paragraph, “employee” shall have the same meaning as set forth in Section 810.2 of the Government Code.

(2) The health authority shall not be considered to be an agency, division, department, or instrumentality of the county and shall not be subject to the personnel, procurement, or other operational rules of the county.

(3) Notwithstanding any other provision of law, any obligations of the health authority, statutory, contractual, or otherwise, shall be the obligations solely of the health authority and shall not be the obligations of the county, unless expressly provided for in a contract between the authority and the county, nor of the state.

(4) Except as agreed to by contract with the county, no liability of the health authority shall become an obligation of the county upon either termination of the health authority or the liquidation or disposition of the health authority’s remaining assets.

(e) (1) To the full extent permitted by federal law, the department and the health authority may enter into contracts to provide or arrange for health care services for any or all persons who are eligible to receive benefits under the Medi-Cal program. The contracts may be on an exclusive or nonexclusive basis, and shall include payment provisions on any basis negotiated between the department and the health authority. The health authority may also enter into contracts for the provision of health care services to individuals including, but not limited to, those covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, individuals employed by public agencies and private businesses, and uninsured or indigent individuals.

(2) Notwithstanding paragraph (1), or subdivision (f), the health authority may not operate health plans or programs for individuals covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, or for private businesses, until the health authority is in full compliance with all of the requirements of the Knox-Keene Health Care Service Plan Act of 1975 under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, including tangible net equity requirements applicable to a licensed health care service plan. This limitation shall not preclude the health authority from enrolling persons pursuant to the county's obligations under Section 17000, or from enrolling county employees.

(f) The board of supervisors may transfer responsibility for administration of county-provided health care services to the health authority for the purpose of service of populations including uninsured and indigent persons, subject to the provisions of any ordinances or resolutions passed by the county board of supervisors. The transfer of administrative responsibility for those health care services shall not relieve the county of its responsibility for indigent care pursuant to Section 17000. The health authority may also enter into contracts for the provision of health care services to individuals including, but not limited to, those covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, and individuals employed by public agencies and private businesses.

(g) Upon creation, the health authority may borrow from the county and the county may lend the authority funds, or issue

revenue anticipation notes to obtain those funds necessary to commence operations or perform the activities of the health authority. Notwithstanding any other provision of law, both the county and the health authority shall be eligible to receive funding under subdivision (p) of Section 14163.

(h) The county may terminate the health authority, but only by an ordinance approved by a two-thirds affirmative vote of the full board.

(i) Prior to the termination of the health authority, the county shall notify the department of its intent to terminate the health authority. The department shall conduct an audit of the health authority's records within 30 days of notification to determine the liabilities and assets of the health authority. The department shall report its findings to the county and to the Department of Managed Health Care within 10 days of completion of the audit. The county shall prepare a plan to liquidate or otherwise dispose of the assets of the health authority and to pay the liabilities of the health authority to the extent of the health authority's assets, and present the plan to the department and the Department of Managed Health Care within 30 days upon receipt of these findings.

(j) Any assets of the health authority derived from the contract entered into between the state and the authority pursuant to Article 2.97 (commencing with Section 14093), after payment of the liabilities of the health authority, shall be disposed of pursuant to the contract.

(k) (1) The governing body shall consist of 18 voting members, 14 of whom shall be appointed by resolution or ordinance of the board as follows:

(A) One member shall be a member of the board or any other person designated by the board.

(B) One member shall be a person who is employed in the senior management of a hospital not operated by the county or the University of California and who is nominated by the San Francisco Section of the West Bay Hospital Conference or any successor organization, or if there is no successor organization, a person who shall be nominated by the Hospital Council of Northern and Central California.

(C) Two members, one of whom shall be a person employed in the senior management of San Francisco General Hospital and one of whom shall be a person employed in the senior management of

St. Luke's Hospital (San Francisco). If San Francisco General Hospital or St. Luke's Hospital, at the end of the term of the person appointed from its senior management, is not designated as a disproportionate share hospital, and if the governing body, after providing an opportunity for comment by the West Bay Hospital Conference, or any successor organization, determines that the hospital no longer serves an equivalent patient population, the governing body may, by a two-thirds vote of the full governing body, select an alternative hospital to nominate a person employed in its senior management to serve on the governing body. Alternatively, the governing body may approve a reduction in the number of positions on the governing body as set forth in subdivision (p).

(D) Two members shall be employees in the senior management of either private nonprofit community clinics or a community clinic consortium, nominated by the San Francisco Community Clinic Consortium, or any successor organization.

(E) Two members shall be physicians, nominated by the San Francisco Medical Society, or any successor organization.

(F) One member shall be nominated by the San Francisco Labor Council, or any successor organization.

(G) Two members shall be persons nominated by the member advisory committee of the health authority. Nominees of the member advisory committee shall be enrolled in any of the health insurance or health care coverage programs operated by the health authority or be the parent or legal guardian of an enrollee in any of the health insurance or health care coverage programs operated by the health authority.

(H) Two members shall be persons knowledgeable in matters relating to either traditional safety net providers, health care organizations, the Medi-Cal program, or the activities of the health authority, nominated by the program committee of the health authority.

(I) One member shall be a person nominated by the San Francisco Pharmacy Leadership Group, or any successor organization.

(2) One member, selected to fulfill the appointments specified in subparagraph (A), (G), or (H) shall, in addition to representing his or her specified organization or employer, represent the

discipline of nursing, and shall possess or be qualified to possess a registered nursing license.

(3) The initial members appointed by the board under the subdivision shall be, to the extent those individuals meet the qualifications set forth in this subdivision and are willing to serve, those persons who are members of the steering committee created by the county to develop the local initiative component of the Medi-Cal state plan in San Francisco. Following the initial staggering of terms, each of those members shall be appointed to a term of three years, except the member appointed pursuant to subparagraph (A) of paragraph (1), who shall serve at the pleasure of the board. At the first meeting of the governing body, the members appointed pursuant to this subdivision shall draw lots to determine seven members whose initial terms shall be for two years. Each member shall remain in office at the conclusion of that member's term until a successor member has been nominated and appointed.

(*l*) In addition to the requirements of subdivision (k), one member of the governing body shall be appointed by the Mayor of the City of San Francisco to serve at the pleasure of the mayor, one member shall be the county's director of public health or designee, who shall serve at the pleasure of that director, one member shall be the Chancellor of the University of California at San Francisco or his or her designee, who shall serve at the pleasure of the chancellor, and one member shall be the county director of mental health or his or her designee, who shall serve at the pleasure of that director.

(m) There shall be one nonvoting member of the governing body who shall be appointed by, and serve at the pleasure of, the health commission of the county.

(n) Each person appointed to the governing body shall, throughout the member's term, either be a resident of the county or be employed within the geographic boundaries of the county.

(o) (1) The composition of the governing body and nomination process for appointment of its members shall be subject to alteration upon a two-thirds vote of the full membership of the governing body. This action shall be concurred in by a resolution or ordinance of the county.

(2) Notwithstanding paragraph (1), no alteration described in that paragraph shall cause the removal of a member prior to the expiration of that member's term.

(p) A majority of the members of the governing body shall constitute a quorum for the transaction of business, and all official acts of the governing body shall require the affirmative vote of a majority of the members present and voting. However, no official shall be approved with less than the affirmative vote of six members of the governing body, unless the number of members prohibited from voting because of conflicts of interest precludes adequate participation in the vote. The governing body may, by a two-thirds vote adopt, amend, or repeal rules and procedures for the governing body. Those rules and procedures may require that certain decisions be made by a vote that is greater than a majority vote.

(q) For purposes of Section 87103 of the Government Code, members appointed pursuant to subparagraphs (B) to (E), inclusive, of paragraph (1) of subdivision (k) represent, and are appointed to represent, respectively, the hospitals, private nonprofit community clinics, and physicians that contract with the health authority, or the health care service plan with which the health authority contracts, to provide health care services to the enrollees of the health authority or the health care service plan. Members appointed pursuant to subparagraphs (F) and (G) of paragraph (1) of subdivision (k) represent, and are appointed to represent, respectively, the health care workers and enrollees served by the health authority or its contracted health care service plan, and traditional safety net and ancillary providers and other organizations concerned with the activities of the health authority.

(r) A member of the governing body may be removed from office by the board by resolution or ordinance, only upon the recommendation of the health authority, and for any of the following reasons:

(1) Failure to retain the qualifications for appointment specified in subdivisions (k) and (n).

(2) Death or a disability that substantially interferes with the member's ability to carry out the duties of office.

(3) Conviction of any felony or a crime involving corruption.

(4) Failure of the member to discharge legal obligations as a member of a public agency.

(5) Substantial failure to perform the duties of office, including, but not limited to, unreasonable absence from meetings. The failure to attend three meetings in a row of the governing body, or a majority of the meetings in the most recent calendar year, may be deemed to be unreasonable absence.

(s) Any vacancy on the governing body, however created, shall be filled for the unexpired term by the board by resolution or ordinance. Each vacancy shall be filled by an individual having the qualifications of his or her predecessor, nominated as set forth in subdivision (k).

(t) The chair of the authority shall be selected by, and serve at the pleasure of, the governing body.

(u) The health authority shall establish all of the following:

(1) A member advisory committee to advise the health authority on issues of concern to the recipients of services.

(2) A program committee to advise the health authority on matters relating to traditional safety net providers, ancillary providers, and other organizations concerned with the activities of the health authority.

(3) Any other committees determined to be advisable by the health authority.

(v) (1) Notwithstanding any provision of state or local law, including, but not limited to, the county charter, a member of the health authority shall not be deemed to be interested in a contract entered into by the authority within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code, or within the meaning of conflict-of-interest restrictions in the county charter, if all of the following apply:

(A) The member does not influence or attempt to influence the health authority or another member of the health authority to enter into the contract in which the member is interested.

(B) The member discloses the interest to the health authority and abstains from voting on the contract.

(C) The health authority notes the member’s disclosure and abstention in its official records and authorizes the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote of the interested member.

(D) The member has an interest in or was appointed to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations.

(E) The contract authorizes the member or the organization the member has an interest in or represents to provide services to beneficiaries under the authority's program or administrative services to the authority.

(2) In addition, no person serving as a member of the governing body shall, by virtue of that membership, be deemed to be engaged in activities that are inconsistent, incompatible, or in conflict with their duties as an officer or employee of the county or the University of California, or as an officer or an employee of any private hospital, clinic, or other health care organization. The membership shall not be deemed to be in violation of Section 1126 of the Government Code.

(w) Notwithstanding any other provision of law, those records of the health authority and of the county that reveal the authority's rates of payment for health care services or the health authority's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services for rates of payment, or the health authority's peer review proceedings shall not be required to be disclosed pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records. However, three years after a contract or amendment to a contract is fully executed, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(x) Notwithstanding any other provision of law, the health authority may meet in closed session to consider and take action on peer review proceedings and on matters pertaining to contracts and contract negotiations by the health authority's staff with providers of health care services concerning all matters relating to rates of payment. However, a decision as to whether to enter into, amend the services provisions of, or terminate, other than for reasons based upon peer review, a contract with a provider of health care services, shall be made in open session.

(y) (1) (A) Notwithstanding the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code), the governing board of the health

authority may meet in closed session for the purpose of discussion of, or taking action on matters involving, health authority trade secrets.

(B) The requirement that the authority make a public report of actions taken in closed session and the vote or abstention of every member present may be limited to a brief general description of the action taken and the vote so as to prevent the disclosure of a trade secret.

(C) For purposes of this subdivision, "health authority trade secret" means a trade secret, as defined in subdivision (d) of Section 3426.1 of the Civil Code, that also meets both of the following criteria:

(i) The secrecy of the information is necessary for the health authority to initiate a new service, program, marketing strategy, business plan, or technology, or to add a benefit or product.

(ii) Premature disclosure of the trade secret would create a substantial probability of depriving the health authority of a substantial economic benefit or opportunity.

(2) Those records of the health authority that reveal the health authority's trade secrets are exempt from disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records. This exemption shall apply for a period of two years after the service, program, marketing strategy, business plan, technology, benefit, or product that is the subject of the trade secret is formally adopted by the governing body of the health authority, provided that the service, program, marketing strategy, business plan, technology, benefit, or product continues to be a trade secret. The governing board may delete the portion or portions containing trade secrets from any documents that were finally approved in the closed session held pursuant to this subdivision that are provided to persons who have made the timely or standing request.

(z) The health authority shall be deemed to be a public agency for purposes of all grant programs and other funding and loan guarantee programs.

(aa) Contracts under this article between the State Department of Health Services and the health authority shall be on a nonbid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(ab) (1) The county controller or his or her designee, at intervals the county controller deems appropriate, shall conduct a review of the fiscal condition of the health authority, shall report the findings to the health authority and the board, and shall provide a copy of the findings to any public agency upon request.

(2) Upon the written request of the county controller, the health authority shall provide full access to the county controller all health authority records and documents as necessary to allow the county controller or his or her designee to perform the activities authorized by this subdivision.

(ac) A Medi-Cal recipient receiving services through the health authority shall be deemed to be a subscriber or enrollee for purposes of Section 1379 of the Health and Safety Code.

SEC. 24. Section 14105.192 of the Welfare and Institutions Code is amended to read:

14105.192. (a) The Legislature finds and declares the following:

(1) Costs within the Medi-Cal program continue to grow due to the rising cost of providing health care throughout the state and also due to increases in enrollment, which are more pronounced during difficult economic times.

(2) In order to minimize the need for drastically cutting enrollment standards or benefits during times of economic crisis, it is crucial to find areas within the program where reimbursement levels are higher than required under the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and can be reduced in accordance with federal law.

(3) The Medi-Cal program delivers its services and benefits to Medi-Cal beneficiaries through a wide variety of health care providers, some of which deliver care via managed care or other contract models while others do so through fee-for-service arrangements.

(4) The setting of rates within the Medi-Cal program is complex and is subject to close supervision by the United States Department of Health and Human Services.

(5) As the single state agency for Medicaid in California, the department has unique expertise that can inform decisions that set or adjust reimbursement methodologies and levels consistent with the requirements of federal law.

(b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and consistent with federal and state law and policies, including any exemptions contained in the provisions of the act that added this section, provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services and products.

(c) Notwithstanding any other provision of law, the director shall adjust provider payments, as specified in this section.

(d) (1) Except as otherwise provided in this section, payments shall be reduced by 10 percent for Medi-Cal fee-for-service benefits for dates of service on and after June 1, 2011.

(2) For managed health care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except contracts with Senior Care Action Network and AIDS Healthcare Foundation, payments shall be reduced by the actuarial equivalent amount of the payment reductions specified in this section pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.

(3) Payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after June 1, 2011. This paragraph shall not apply to inpatient hospital services provided in a hospital that is paid under contract pursuant to Article 2.6 (commencing with Section 14081).

(4) (A) Notwithstanding any other provision of law, the director may adjust the payments specified in paragraphs (1) and (3) of this subdivision with respect to one or more categories of Medi-Cal providers, or for one or more products or services rendered, or any combination thereof, so long as the resulting reductions to any category of Medi-Cal providers, in the aggregate, total no more than 10 percent.

(B) The adjustments authorized in subparagraph (A) shall be implemented only if the director determines that, for each affected product, service, or provider category, the payments resulting from the adjustment comply with subdivision (m).

(e) Notwithstanding any other provision of this section, payments to hospitals that are not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) for inpatient hospital services provided to Medi-Cal beneficiaries and that are subject to Section 14166.245 shall be governed by that section.

(f) Notwithstanding any other provision of this section, the following shall apply:

(1) Payments to providers that are paid pursuant to Article 3.8 (commencing with Section 14126) shall be governed by that article.

(2) (A) Subject to subparagraph (B), for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates for intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, as determined by the applicable methodology for setting reimbursement rates for these facilities, shall not exceed the reimbursement rates that were applicable to providers in the 2008–09 rate year.

(B) (i) If Section 14105.07 is added to the Welfare and Institutions Code during the 2011–12 Regular Session of the Legislature, subparagraph (A) shall become inoperative.

(ii) If Section 14105.07 is added to the Welfare and Institutions Code during the 2011–12 Regular Session of the Legislature, then for dates of service on and after June 1, 2011, payments to intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, shall be governed by the applicable methodology for setting reimbursement rates for these facilities and by Section 14105.07.

(g) The department may enter into contracts with a vendor for the purposes of implementing this section on a bid or nonbid basis. In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this subdivision is necessary. Therefore, contracts entered into to implement this section and all contract amendments and change orders shall be

exempt from Chapter 2 (commencing with Section 10290) of Part 2 Division 2 of the Public Contract Code.

(h) To the extent applicable, the services, facilities, and payments listed in this subdivision shall be exempt from the payment reductions specified in subdivision (d) as follows:

(1) Acute hospital inpatient services that are paid under contracts pursuant to Article 2.6 (commencing with Section 14081).

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver pursuant to subsection (a) of Section 1115 of the federal Social Security Act (42 U.S.C. Sec. 1315(a)).

(3) Rural health clinic services.

(4) Payments to facilities owned or operated by the State Department of State Hospitals or the State Department of Developmental Services.

(5) Hospice services.

(6) Contract services, as designated by the director pursuant to subdivision (k).

(7) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations. This paragraph shall apply to payments described in paragraph (3) of subdivision (d) only to the extent that they are also exempt from reduction pursuant to subdivision (*l*).

(8) Services pursuant to local assistance contracts and interagency agreements to the extent the funding is not included in the funds appropriated to the department in the annual Budget Act.

(9) Breast and cervical cancer treatment provided pursuant to Section 14007.71 and as described in paragraph (3) of subdivision (a) of Section 14105.18 or Article 1.5 (commencing with Section 104160) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code.

(10) The Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to subdivision (aa) of Section 14132.

(i) Subject to the exception for services listed in subdivision (h), the payment reductions required by subdivision (d) shall apply to the benefits rendered by any provider who may be authorized to bill for the service, including, but not limited to, physicians,

podiatrists, nurse practitioners, certified nurse-midwives, nurse anesthetists, and organized outpatient clinics.

(j) Notwithstanding any other provision of law, for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates applicable to the following classes of providers shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008–09 rate year, as described in subdivision (f) of Section 14105.191, reduced by 10 percent:

(1) Intermediate care facilities, excluding those facilities identified in paragraph (2) of subdivision (f). For purposes of this section, "intermediate care facility" has the same meaning as defined in Section 51118 of Title 22 of the California Code of Regulations.

(2) Skilled nursing facilities that are distinct parts of general acute care hospitals. For purposes of this section, "distinct part" has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(3) Rural swing-bed facilities.

(4) Subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this subparagraph, "subacute care unit" has the same meaning as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(5) Pediatric subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this subparagraph, "pediatric subacute care unit" has the same meaning as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(6) Adult day health care centers.

(7) Freestanding pediatric subacute care units, as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer this section by means of provider bulletins or similar instructions, without taking regulatory action.

(*l*) The reductions described in this section shall apply only to payments for services when the General Fund share of the payment is paid with funds directly appropriated to the department in the annual Budget Act and shall not apply to payments for services paid with funds appropriated to other departments or agencies.

(m) Notwithstanding any other provision of this section, the payment reductions and adjustments provided for in subdivision (d) shall be implemented only if the director determines that the payments that result from the application of this section will comply with applicable federal Medicaid requirements and that federal financial participation will be available.

(1) In determining whether federal financial participation is available, the director shall determine whether the payments comply with applicable federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(2) To the extent that the director determines that the payments do not comply with the federal Medicaid requirements or that federal financial participation is not available with respect to any payment that is reduced pursuant to this section, the director retains the discretion to not implement the particular payment reduction or adjustment and may adjust the payment as necessary to comply with federal Medicaid requirements.

(n) The department shall seek any necessary federal approvals for the implementation of this section.

(o) (1) The payment reductions and adjustments set forth in this section shall not be implemented until federal approval is obtained.

(2) To the extent that federal approval is obtained for one or more of the payment reductions and adjustments in this section and Section 14105.07, the payment reductions and adjustments set forth in Section 14105.191 shall cease to be implemented for the same services provided by the same class of providers. In the event of a conflict between this section and Section 14105.191, other than the provisions setting forth a payment reduction or adjustment, this section shall govern.

(3) When federal approval is obtained, the payments resulting from the application of this section shall be implemented retroactively to June 1, 2011, or on any other date or dates as may be applicable.

(4) The director may clarify the application of this subdivision by means of provider bulletins or similar instructions, pursuant to subdivision (k).

(p) Adjustments to pharmacy drug product payment pursuant to this section shall no longer apply when the department

determines that the average acquisition cost methodology pursuant to Section 14105.45 has been fully implemented and the department's pharmacy budget reduction targets, consistent with payment reduction levels pursuant to this section, have been met.

SEC. 25. Section 14124.5 of the Welfare and Institutions Code is amended to read:

14124.5. (a) The director may, in accordance with Section 10725, adopt, amend, or repeal, in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, reasonable rules and regulations as may be necessary or proper to carry out the purposes and intent of this chapter, and to enable the department to exercise the powers and perform the duties conferred upon it by this chapter, not inconsistent with any statute of this state.

(b) All regulations previously adopted by the State Department of Health Care Services or any predecessor department pursuant to this chapter and in effect immediately preceding the operative date of this section, shall remain in effect and shall be fully enforceable unless and until readopted, amended, or repealed by the director in accordance with Section 10725.

SEC. 26. Section 14169.51 of the Welfare and Institutions Code is amended to read:

14169.51. For purposes of this article, the following definitions shall apply:

(a) "Acute psychiatric days" means the total number of Medi-Cal specialty mental health service administrative days, Medi-Cal specialty mental health service acute care days, acute psychiatric administrative days, and acute psychiatric acute days identified in the Final Medi-Cal Utilization Statistics for the state fiscal year preceding the rebase calculation year as calculated by the department as of the retrieval date.

(b) "Acute psychiatric per diem supplemental rate" means a fixed per diem supplemental payment for acute psychiatric days.

(c) "Annual fee-for-service days" means the number of fee-for-service days of each hospital subject to the quality assurance fee, as reported on the days data source.

(d) "Annual managed care days" means the number of managed care days of each hospital subject to the quality assurance fee, as reported on the days data source.

(e) "Annual Medi-Cal days" means the number of Medi-Cal days of each hospital subject to the quality assurance fee, as reported on the days data source.

(f) "Base calendar year" means a calendar year that ends before a subject fiscal year begins, but no more than six years before a subject fiscal year begins. Beginning with the third program period, the department shall establish the base calendar year during the rebase calculation year as the calendar year for which the most recent data is available that the department determines is reliable.

(g) "Converted hospital" means a private hospital that becomes a designated public hospital or a nondesignated public hospital on or after the first day of a program period.

(h) "Days data source" means either: (1) if a hospital's Annual Financial Disclosure Report for its fiscal year ending in the base calendar year includes data for a full fiscal year of operation, the hospital's Annual Financial Disclosure Report retrieved from the Office of Statewide Health Planning and Development as retrieved by the department on the retrieval date pursuant to Section 14169.59, for its fiscal year ending in the base calendar year; or (2) if a hospital's Annual Financial Disclosure Report for its fiscal year ending in the base calendar year includes data for more than one day, but less than a full year of operation, the department's best and reasonable estimates of the hospital's Annual Financial Disclosure Report if the hospital had operated for a full year.

(i) "Department" means the State Department of Health Care Services.

(j) "Designated public hospital" shall have the meaning given in subdivision (d) of Section 14166.1.

(k) "Director" means the Director of Health Care Services.

(*l*) "Exempt facility" means any of the following:

(1) A public hospital, which shall include either of the following:

(A) A hospital, as defined in paragraph (25) of subdivision (a) of Section 14105.98.

(B) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code and operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(2) With the exception of a hospital that is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, a hospital that is designated as a specialty hospital in the hospital's most recently filed Office of Statewide Health Planning and Development Hospital Annual Financial Disclosure Report, as of the first day of a program period.

(3) A hospital that satisfies the Medicare criteria to be a long-term care hospital.

(4) A small and rural hospital as specified in Section 124840 of the Health and Safety Code designated as that in the hospital's most recently filed Office of Statewide Health Planning and Development Hospital Annual Financial Disclosure Report, as of the first day of a program period.

(m) "Federal approval" means the approval by the federal government of both the quality assurance fee established pursuant to this article and the supplemental payments to private hospitals described pursuant to this article.

(n) "Fee-for-service per diem quality assurance fee rate" means a fixed fee on fee-for-service days.

(o) "Fee-for-service days" means inpatient hospital days as reported on the days data source where the service type is reported as "acute care," "psychiatric care," or "rehabilitation care," and the payer category is reported as "Medicare traditional," "county indigent programs-traditional," "other third parties-traditional," "other indigent," or "other payers," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(p) "Fund" means the Hospital Quality Assurance Revenue Fund established by Section 14167.35.

(q) "General acute care days" means the total number of Medi-Cal general acute care days, including well baby days, less any acute psychiatric inpatient days, paid by the department to a hospital for services in the base calendar year, as reflected in the state paid claims file on the retrieval date.

(r) "General acute care hospital" means any hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(s) "General acute care per diem supplemental rate" means a fixed per diem supplemental payment for general acute care days.

(t) "High acuity days" means Medi-Cal coronary care unit days, pediatric intensive care unit days, intensive care unit days, neonatal intensive care unit days, and burn unit days paid by the department to a hospital for services in the base calendar year, as reflected in the state paid claims file prepared by the department on the retrieval date.

(u) "High acuity per diem supplemental rate" means a fixed per diem supplemental payment for high acuity days for specified hospitals in Section 14169.55.

(v) "High acuity trauma per diem supplemental rate" means a fixed per diem supplemental payment for high acuity days for specified hospitals in Section 14169.55 that have been designated as specified types of trauma hospitals.

(w) "Hospital community" includes, but is not limited to, the statewide hospital industry organization and systems representing general acute care hospitals.

(x) "Hospital inpatient services" means all services covered under Medi-Cal and furnished by hospitals to patients who are admitted as hospital inpatients and reimbursed on a fee-for-service basis by the department directly or through its fiscal intermediary. Hospital inpatient services include outpatient services furnished by a hospital to a patient who is admitted to that hospital within 24 hours of the provision of the outpatient services that are related to the condition for which the patient is admitted. Hospital inpatient services do not include services for which a managed health care plan is financially responsible.

(y) "Hospital outpatient services" means all services covered under Medi-Cal furnished by hospitals to patients who are registered as hospital outpatients and reimbursed by the department on a fee-for-service basis directly or through its fiscal intermediary. Hospital outpatient services do not include services for which a managed health care plan is financially responsible, or services rendered by a hospital-based federally qualified health center for which reimbursement is received pursuant to Section 14132.100.

(z) "Managed care days" means inpatient hospital days as reported on the days data source where the service type is reported as "acute care," "psychiatric care," or "rehabilitation care," and the payer category is reported as "Medicare managed care," "county indigent programs-managed care," or "other third parties-managed care," for purposes of the Annual Financial

Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(aa) "Managed care per diem quality assurance fee rate" means a fixed fee on managed care days.

(ab) (1) "Managed health care plan" means a health care delivery system that manages the provision of health care and receives prepaid capitated payments from the state in return for providing services to Medi-Cal beneficiaries.

(2) (A) Managed health care plans include county organized health systems and entities contracting with the department to provide or arrange services for Medi-Cal beneficiaries pursuant to the two-plan model, geographic managed care, or regional managed care for the rural expansion. Entities providing these services contract with the department pursuant to any of the following:

(i) Article 2.7 (commencing with Section 14087.3).

(ii) Article 2.8 (commencing with Section 14087.5).

(iii) Article 2.81 (commencing with Section 14087.96).

(iv) Article 2.82 (commencing with Section 14087.98).

(v) Article 2.91 (commencing with Section 14089).

(B) Managed health care plans do not include any of the following:

(i) Mental health plans contracting to provide mental health care for Medi-Cal beneficiaries pursuant to Chapter 8.9 (commencing with Section 14700).

(ii) Health plans not covering inpatient services such as primary care case management plans operating pursuant to Section 14088.85.

(iii) Program of All-Inclusive Care for the Elderly organizations operating pursuant to Chapter 8.75 (commencing with Section 14591).

(ac) "Medi-Cal days" means inpatient hospital days as reported on the days data source where the service type is reported as "acute care," "psychiatric care," or "rehabilitation care," and the payer category is reported as "Medi-Cal traditional" or "Medi-Cal managed care," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(ad) "Medi-Cal fee-for-service days" means inpatient hospital days as reported on the days data source where the service type is

reported as “acute care,” “psychiatric care,” or “rehabilitation care,” and the payer category is reported as “Medi-Cal traditional” for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(ae) “Medi-Cal managed care days” means the total number of general acute care days, including well baby days, listed for the county organized health system and prepaid health plans identified in the Final Medi-Cal Utilization Statistics for the state fiscal year preceding the rebase calculation year, as calculated by the department as of the retrieval date.

(af) “Medi-Cal managed care fee days” means inpatient hospital days as reported on the days data source where the service type is reported as “acute care,” “psychiatric care,” or “rehabilitation care,” and the payer category is reported as “Medi-Cal managed care” for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(ag) “Medi-Cal per diem quality assurance fee rate” means a fixed fee on Medi-Cal days.

(ah) “Medicaid inpatient utilization rate” means Medicaid inpatient utilization rate as defined in Section 1396r-4 of Title 42 of the United States Code and as set forth in the Final Medi-Cal Utilization Statistics for the state fiscal year preceding the rebase calculation year, as calculated by the department as of the retrieval date.

(ai) “New hospital” means a hospital operation, business, or facility functioning under current or prior ownership as a private hospital that does not have a days data source or a hospital that has a days data source in whole, or in part, from a previous operator where there is an outstanding monetary obligation owed to the state in connection with the Medi-Cal program and the hospital is not, or does not agree to become, financially responsible to the department for the outstanding monetary obligation in accordance with subdivision (d) of Section 14169.61.

(aj) “Nondesignated public hospital” means either of the following:

(1) A public hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital’s most recently filed Annual

Financial Disclosure Report, as of the first day of a program period, and satisfies the definition in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(2) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's most recently filed Annual Financial Disclosure Report, as of the first day of a program period, is operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(ak) "Outpatient base amount" means the total amount of payments for hospital outpatient services made to a hospital in the base calendar year, as reflected in the state paid claims files prepared by the department as of the retrieval date.

(al) "Outpatient supplemental rate" means a fixed proportional supplemental payment for Medi-Cal outpatient services.

(am) "Prepaid health plan hospital" means a hospital owned by a nonprofit public benefit corporation that shares a common board of directors with a nonprofit health care service plan, which exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan, as of the effective date of this article.

(an) "Prepaid health plan hospital managed care per diem quality assurance fee rate" means a fixed fee on non-Medi-Cal managed care fee days for prepaid health plan hospitals.

(ao) "Prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate" means a fixed fee on Medi-Cal managed care fee days for prepaid health plan hospitals.

(ap) "Private hospital" means a hospital that meets all of the following conditions:

(1) Is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital's most recently filed Office of Statewide Health Planning and Development Annual Financial Disclosure Report, as of the first day of a program period.

(3) Does not satisfy the Medicare criteria to be classified as a long-term care hospital.

(4) Is a nonpublic hospital, nonpublic converted hospital, or converted hospital as those terms are defined in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98.

(5) Is not a nondesignated public hospital or a designated public hospital.

(aq) "Program period" means a period not to exceed three years during which a fee model and a supplemental payment model developed under this article shall be effective. The first program period shall be the period beginning January 1, 2014, and ending December 31, 2016, inclusive. The second program period shall be the period beginning on January 1, 2017, and ending June 30, 2019. Each subsequent program period shall begin on the day immediately following the last day of the immediately preceding program period and shall end on the last day of a state fiscal year, as determined by the department.

(ar) "Quality assurance fee" means the quality assurance fee assessed pursuant to Section 14169.52 and collected on the basis of the quarterly quality assurance fee.

(as) (1) "Quarterly quality assurance fee" means, with respect to a hospital that is not a prepaid health plan hospital, the sum of all of the following:

(A) The annual fee-for-service days for an individual hospital multiplied by the fee-for-service per diem quality assurance fee rate, divided by four.

(B) The annual managed care days for an individual hospital multiplied by the managed care per diem quality assurance fee rate, divided by four.

(C) The annual Medi-Cal days for an individual hospital multiplied by the Medi-Cal per diem quality assurance fee rate, divided by four.

(2) "Quarterly quality assurance fee" means, with respect to a hospital that is a prepaid health plan hospital, the sum of all of the following:

(A) The annual fee-for-service days for an individual hospital multiplied by the fee-for-service per diem quality assurance fee rate, divided by four.

(B) The annual managed care days for an individual hospital multiplied by the prepaid health plan hospital managed care per diem quality assurance fee rate, divided by four.

(C) The annual Medi-Cal managed care fee days for an individual hospital multiplied by the prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate, divided by four.

(D) The annual Medi-Cal fee-for-service days for an individual hospital multiplied by the Medi-Cal per diem quality assurance fee rate, divided by four.

(at) "Rebase calculation year" means a state fiscal year during which the department shall rebase the data, including, but not limited to, the days data source, used for the following: acute psychiatric days, annual fee-for-service days, annual managed care days, annual Medi-Cal days, fee-for-service days, general acute care days, high acuity days, managed care days, Medi-Cal days, Medi-Cal fee-for-service days, Medi-Cal managed care days, Medi-Cal managed care fee days, outpatient base amount, and transplant days, pursuant to Section 14169.59. Beginning with the third program period, the rebase calculation year for a program period shall be the last subject fiscal year of the immediately preceding program period.

(au) "Rebase year" means the first state fiscal year of a program period and shall immediately follow a rebase calculation year.

(av) "Retrieval date" means a day for each data element during the last quarter of the rebase calculation year upon which the department retrieves the data, including, but not limited to, the days data source, used for the following: acute psychiatric days, annual fee-for-service days, annual managed care days, annual Medi-Cal days, fee-for-service days, general acute care days, high acuity days, managed care days, Medi-Cal days, Medi-Cal fee-for-service days, Medi-Cal managed care days, Medi-Cal managed care fee days, outpatient base amount, and transplant days, pursuant to Section 14169.59. The retrieval date for each data element may be a different date within the quarter as determined to be necessary and appropriate by the department.

(aw) "Subacute supplemental rate" means a fixed proportional supplemental payment for acute inpatient services based on a hospital's prior provision of Medi-Cal subacute services.

(ax) "Subject fiscal quarter" means a state fiscal quarter beginning on or after the first day of a program period and ending on or before the last day of a program period.

(ay) "Subject fiscal year" means a state fiscal year beginning on or after the first day of a program period and ending on or before the last day of a program period.

(az) "Subject month" means a calendar month beginning on or after the first day of a program period and ending on or before the last day of a program period.

(ba) "Transplant days" means the number of Medi-Cal days for Medicare Severity-Diagnosis Related Groups (MS-DRGs) 1, 2, 5 to 10, inclusive, 14, 15, or 652, according to the Patient Discharge Data File Documentation from the Office of Statewide Health Planning and Development for the base calendar year accessed on the retrieval date.

(bb) "Transplant per diem supplemental rate" means a fixed per diem supplemental payment for transplant days.

(bc) "Upper payment limit" means a federal upper payment limit on the amount of the Medicaid payment for which federal financial participation is available for a class of service and a class of health care providers, as specified in Part 447 of Title 42 of the Code of Federal Regulations. The applicable upper payment limit shall be separately calculated for inpatient and outpatient hospital services.

SEC. 27. Section 14169.52 of the Welfare and Institutions Code is amended to read:

14169.52. (a) There shall be imposed on each general acute care hospital that is not an exempt facility a quality assurance fee, except that a quality assurance fee under this article shall not be imposed on a converted hospital for the periods when the hospital is a public hospital or a new hospital with respect to a program period.

(b) The department shall compute the quarterly quality assurance fee for each subject fiscal year during a program period pursuant to Section 14169.59.

(c) Subject to Section 14169.63, on the later of the date of the department's receipt of federal approval or the first day of each program period, the following shall commence:

(1) Within 10 business days following receipt of the notice of federal approval, the department shall send notice to each hospital

subject to the quality assurance fee, which shall contain the following information:

(A) The date that the state received notice of federal approval.

(B) The quarterly quality assurance fee for each subject fiscal year.

(C) The date on which each payment is due.

(2) The hospitals shall pay the quarterly quality assurance fee, based on a schedule developed by the department. The department shall establish the date that each payment is due, provided that the first payment shall be due no earlier than 20 days following the department sending the notice pursuant to paragraph (1), and the payments shall be paid at least one month apart, but if possible, the payments shall be paid on a quarterly basis.

(3) Notwithstanding any other provision of this section, the amount of each hospital's quarterly quality assurance fee for a program period that has not been paid by the hospital before 15 days prior to the end of a program period shall be paid by the hospital no later than 15 days prior to the end of a program period.

(4) Each hospital described in subdivision (a) shall pay the quarterly quality assurance fees that are due, if any, in the amounts and at the times set forth in the notice unless superseded by a subsequent notice from the department.

(d) The quality assurance fee, as assessed pursuant to this section, shall be paid by each hospital subject to the fee to the department for deposit in the fund. Deposits may be accepted at any time and shall be credited toward the program period for which the fees were assessed. This article shall not affect the ability of a hospital to pay fees assessed for a program period after the end of that program period.

(e) This section shall become inoperative if the federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before December 1, 2016, the implementation of the quality assurance fee pursuant to this article or the supplemental payments to private hospitals pursuant to this article for the first program period.

(f) In no case shall the aggregate fees collected in a federal fiscal year pursuant to this section, former Section 14167.32, Section 14168.32, and Section 14169.32 exceed the maximum percentage of the annual aggregate net patient revenue for hospitals subject to the fee that is prescribed pursuant to federal law and regulations

as necessary to preclude a finding that an indirect guarantee has been created.

(g) (1) Interest shall be assessed on quality assurance fees not paid on the date due at the greater of 10 percent per annum or the rate at which the department assesses interest on Medi-Cal program overpayments to hospitals that are not repaid when due. Interest shall begin to accrue the day after the date the payment was due and shall be deposited in the fund.

(2) In the event that any fee payment is more than 60 days overdue, a penalty equal to the interest charge described in paragraph (1) shall be assessed and due for each month for which the payment is not received after 60 days.

(h) When a hospital fails to pay all or part of the quality assurance fee on or before the date that payment is due, the department may immediately begin to deduct the unpaid assessment and interest from any Medi-Cal payments owed to the hospital, or, in accordance with Section 12419.5 of the Government Code, from any other state payments owed to the hospital until the full amount is recovered. All amounts, except penalties, deducted by the department under this subdivision shall be deposited in the fund. The remedy provided to the department by this section is in addition to other remedies available under law.

(i) The payment of the quality assurance fee shall not be considered as an allowable cost for Medi-Cal cost reporting and reimbursement purposes.

(j) The department shall work in consultation with the hospital community to implement this article.

(k) This subdivision creates a contractually enforceable promise on behalf of the state to use the proceeds of the quality assurance fee, including any federal matching funds, solely and exclusively for the purposes set forth in this article, to limit the amount of the proceeds of the quality assurance fee to be used to pay for the health care coverage of children as provided in Section 14169.53, to limit any payments for the department's costs of administration to the amounts set forth in this article, to maintain and continue prior reimbursement levels as set forth in Section 14169.68 on the effective date of that section, and to otherwise comply with all its obligations set forth in this article, provided that amendments that arise from, or have as a basis for, a decision, advice, or determination by the federal Centers for Medicare and Medicaid

Services relating to federal approval of the quality assurance fee or the payments set forth in this article shall control for the purposes of this subdivision.

(*l*) (1) Subject to paragraph (2), the director may waive any or all interest and penalties assessed under this article in the event that the director determines, in his or her sole discretion, that the hospital has demonstrated that imposition of the full quality assurance fee on the timelines applicable under this article has a high likelihood of creating a financial hardship for the hospital or a significant danger of reducing the provision of needed health care services.

(2) Waiver of some or all of the interest or penalties under this subdivision shall be conditioned on the hospital's agreement to make fee payments, or to have the payments withheld from payments otherwise due from the Medi-Cal program to the hospital, on a schedule developed by the department that takes into account the financial situation of the hospital and the potential impact on services.

(3) A decision by the director under this subdivision shall not be subject to judicial review.

(4) If fee payments are remitted to the department after the date determined by the department to be the final date for calculating the final supplemental payments for a program period under this article, the fee payments shall be refunded to general acute care hospitals, pro rata with the amount of quality assurance fee paid by the hospital in the program period, subject to the limitations of federal law. If federal rules prohibit the refund described in this paragraph, the excess funds shall be used as quality assurance fees for the next program period for general acute care hospitals, pro rata with the quality assurance fees paid by the hospital for the program period.

(5) If during the implementation of this article, fee payments that were due under former Article 5.21 (commencing with Section 14167.1) and former Article 5.22 (commencing with Section 14167.31), or former Article 5.226 (commencing with Section 14168.1) and Article 5.227 (commencing with Section 14168.31), or Article 5.228 (commencing with Section 14169.1) and Article 5.229 (commencing with Section 14169.31) are remitted to the department under a payment plan or for any other reason, and the final date for calculating the final supplemental payments under

those articles has passed, then those fee payments shall be deposited in the fund to support the uses established by this article.

SEC. 28. Section 14169.53 of the Welfare and Institutions Code is amended to read:

14169.53. (a) (1) All fees required to be paid to the state pursuant to this article shall be paid in the form of remittances payable to the department.

(2) The department shall directly transmit the fee payments to the Treasurer to be deposited in the fund. Notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on deposits in the fund from the proceeds of the fee assessed pursuant to this article shall be retained in the fund for purposes specified in subdivision (b).

(b) (1) Notwithstanding subdivision (c) of Section 14167.35, subdivision (b) of Section 14168.33, and subdivision (b) of Section 14169.33, all funds from the proceeds of the fee assessed pursuant to this article in the fund, together with any interest and dividends earned on money in the fund, shall continue to be used exclusively to enhance federal financial participation for hospital services under the Medi-Cal program, to provide additional reimbursement to, and to support quality improvement efforts of, hospitals, and to minimize uncompensated care provided by hospitals to uninsured patients, as well as to pay for the state's administrative costs and to provide funding for children's health coverage, in the following order of priority:

(A) To pay for the department's staffing and administrative costs directly attributable to implementing this article, not to exceed two hundred fifty thousand dollars ($250,000) for each subject fiscal quarter, exclusive of any federal matching funds.

(B) To pay for the health care coverage, as described in subdivision (g), except that for the two subject fiscal quarters in the 2013–14 fiscal year, the amount for children's health care coverage shall be one hundred fifty-five million dollars ($155,000,000) for each subject fiscal quarter, exclusive of any federal matching funds.

(C) To make increased capitation payments to managed health care plans pursuant to this article and Section 14169.82, including the nonfederal share of capitation payments to managed health care plans pursuant to this article and Section 14169.82 for services provided to individuals who meet the eligibility requirements in

Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)).

(D) To make increased payments and direct grants to hospitals pursuant to this article and Section 14169.83, including the nonfederal share of payments to hospitals under this article and Section 14169.83 for services provided to individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)).

(2) Notwithstanding subdivision (c) of Section 14167.35, subdivision (b) of Section 14168.33, and subdivision (b) of Section 14169.33, and notwithstanding Section 13340 of the Government Code, the moneys in the fund shall be continuously appropriated during the first program period only, without regard to fiscal year, for the purposes of this article, Article 5.229 (commencing with Section 14169.31), Article 5.228 (commencing with Section 14169.1), Article 5.227 (commencing with Section 14168.31), former Article 5.226 (commencing with Section 14168.1), former Article 5.22 (commencing with Section 14167.31), and former Article 5.21 (commencing with Section 14167.1).

(3) For subsequent program periods, the moneys in the fund shall be used, upon appropriation by the Legislature in the annual Budget Act, for the purposes of this article and Sections 14169.82 and 14169.83.

(c) Any amounts of the quality assurance fee collected in excess of the funds required to implement subdivision (b), including any funds recovered under subdivision (d) of Section 14169.61, shall be refunded to general acute care hospitals, pro rata with the amount of quality assurance fee paid by the hospital, subject to the limitations of federal law. If federal rules prohibit the refund described in this subdivision, the excess funds shall be used as quality assurance fees for the next program period for general acute care hospitals, pro rata with the amount of quality assurance fees paid by the hospital for the program period.

(d) Any methodology or other provision specified in this article may be modified by the department, in consultation with the

hospital community, to the extent necessary to meet the requirements of federal law or regulations to obtain federal approval or to enhance the probability that federal approval can be obtained, provided the modifications do not violate the spirit, purposes, and intent of this article and are not inconsistent with the conditions of implementation set forth in Section 14169.72. The department shall notify the Joint Legislative Budget Committee and the fiscal and appropriate policy committees of the Legislature 30 days prior to implementation of a modification pursuant to this subdivision.

(e) The department, in consultation with the hospital community, shall make adjustments, as necessary, to the amounts calculated pursuant to Section 14169.52 in order to ensure compliance with the federal requirements set forth in Section 433.68 of Title 42 of the Code of Federal Regulations or elsewhere in federal law.

(f) The department shall request approval from the federal Centers for Medicare and Medicaid Services for the implementation of this article. In making this request, the department shall seek specific approval from the federal Centers for Medicare and Medicaid Services to exempt providers identified in this article as exempt from the fees specified, including the submission, as may be necessary, of a request for waiver of the broad-based requirement, waiver of the uniform fee requirement, or both, pursuant to paragraphs (1) and (2) of subdivision (e) of Section 433.68 of Title 42 of the Code of Federal Regulations.

(g) (1) For purposes of this subdivision, the following definitions shall apply:

(A) "Actual net benefit" means the net benefit determined by the department for a net benefit period after the conclusion of the net benefit period using payments and grants actually made, and fees actually collected, for the net benefit period.

(B) "Aggregate fees" means the aggregate fees collected from hospitals under this article.

(C) "Aggregate payments" means the aggregate payments and grants made directly or indirectly to hospitals under this article, including payments and grants described in Sections 14169.54, 14169.55, 14169.57, and 14169.58, and subdivision (b) of Section 14169.82.

(D) "Net benefit" means the aggregate payments for a net benefit period minus the aggregate fees for the net benefit period.

(E) "Net benefit period" means a subject fiscal year or portion thereof that is in a program period and begins on or after July 1, 2014.

(F) "Preliminary net benefit" means the net benefit determined by the department for a net benefit period prior to the beginning of that net benefit period using estimated or projected data.

(2) The amount of funding provided for children's health care coverage under subdivision (b) for a net benefit period shall be equal to 24 percent of the net benefit for that net benefit period.

(3) The department shall determine the preliminary net benefit for all net benefit periods in the first program period before July 1, 2014. The department shall determine the preliminary net benefit for all net benefit periods in a subsequent program period before the beginning of the program period.

(4) The department shall determine the actual net benefit and make the reconciliation described in paragraph (5) for each net benefit period within six months after the date determined by the department pursuant to subdivision (h).

(5) For each net benefit period, the department shall reconcile the amount of moneys in the fund used for children's health coverage based on the preliminary net benefit with the amount of the fund that may be used for children's health coverage under this subdivision based on the actual net benefit. For each net benefit period, any amounts that were in the fund and used for children's health coverage in excess of the 24 percent of the actual net benefit shall be returned to the fund, and the amount, if any, by which 24 percent of the actual net benefit exceeds 24 percent of the preliminary net benefit shall be available from the fund to the department for children's health coverage. The department shall notify the Joint Legislative Budget Committee and the fiscal and appropriate policy committees of the Legislature of the results of the reconciliation for each net benefit period pursuant to this paragraph within five working days of performing the reconciliation.

(6) The department shall make all calculations and reconciliations required by this subdivision in consultation with the hospital community using data that the department determines is the best data reasonably available.

(h) After consultation with the hospital community, the department shall determine a date upon which substantially all

fees have been paid and substantially all supplemental payments, grants, and rate range increases have been made for a program period, which date shall be no later than two years after the end of a program period. After the date determined by the department pursuant to this subdivision, no further supplemental payments shall be made under the program period, and any fees collected with respect to the program period shall be used for a subsequent program period consistent with this section. Nothing in this subdivision shall affect the department's authority to collect quality assurance fees for a program period after the end of the program period or after the date determined by the department pursuant to this subdivision. The department shall notify the Joint Legislative Budget Committee and fiscal and appropriate policy committees of that date within five working days of the determination.

(i) Use of the fee proceeds to enhance federal financial participation pursuant to subdivision (b) shall include use of the proceeds to supply the nonfederal share, if any, of payments to hospitals under this article for services provided to individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)) such that expenditures for services provided to the individual are eligible for the enhanced federal medical assistance percentage described in that section.

SEC. 29. Section 14169.55 of the Welfare and Institutions Code is amended to read:

14169.55. (a) Private hospitals shall be paid supplemental amounts for the provision of hospital inpatient services for each subject fiscal quarter in a program period as set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services and shall not affect any other payments to hospitals. The inpatient supplemental amounts shall result in payments to hospitals that equal the applicable federal upper payment limit for the subject fiscal year, except that with respect to a subject fiscal year that begins before the start of a program period or that ends after the end of the program period for which the payments are made, the inpatient supplemental amounts shall result in payments to hospitals that equal a percentage of the applicable upper payment limit where

the percentage equals the percentage of the subject fiscal year that occurs during the program period.

(b) Except as set forth in subdivisions (e) and (f), each private hospital shall be paid the sum of the following amounts as applicable for the provision of hospital inpatient services for each subject fiscal quarter:

(1) A general acute care per diem supplemental rate multiplied by the hospital's general acute care days.

(2) An acute psychiatric per diem supplemental rate multiplied by the hospital's acute psychiatric days.

(3) A high acuity per diem supplemental rate multiplied by the number of the hospital's high acuity days if the hospital's Medicaid inpatient utilization rate is less than the percent required to be eligible to receive disproportionate share replacement funds for the state fiscal year ending in the base calendar year and greater than 5 percent and at least 5 percent of the hospital's general acute care days are high acuity days.

(4) A high acuity trauma per diem supplemental rate multiplied by the number of the hospital's high acuity days if the hospital qualifies to receive the amount set forth in paragraph (3) and has been designated as a Level I, Level II, Adult/Ped Level I, or Adult/Ped Level II trauma center by the Emergency Medical Services Authority established pursuant to Section 1797.1 of the Health and Safety Code.

(5) A transplant per diem supplemental rate multiplied by the number of the hospital's transplant days if the hospital's Medicaid inpatient utilization rate is less than the percent required to be eligible to receive disproportionate share replacement funds for the state fiscal year ending in the base calendar year and greater than 5 percent.

(6) A payment for hospital inpatient services equal to the subacute supplemental rate multiplied by the Medi-Cal subacute payments as reflected in the state paid claims file prepared by the department as of the retrieval date for the base calendar year if the private hospital provided Medi-Cal subacute services during the base calendar year.

(c) In the event federal financial participation for a subject fiscal year is not available for all of the supplemental amounts payable to private hospitals under subdivision (b) due to the application of

an upper payment limit or for any other reason, both of the following shall apply:

(1) The total amount payable to private hospitals under subdivision (b) for the subject fiscal year shall be reduced to reflect the amount for which federal financial participation is available.

(2) The amount payable under subdivision (b) to each private hospital for the subject fiscal year shall be equal to the amount computed under subdivision (b) multiplied by the ratio of the total amount for which federal financial participation is available to the total amount computed under subdivision (b).

(d) If the amount otherwise payable to a hospital under this section for a subject fiscal year exceeds the amount for which federal financial participation is available for that hospital, the amount due to the hospital for that subject fiscal year shall be reduced to the amount for which federal financial participation is available.

(e) Payments shall not be made under this section for the periods when a hospital is a new hospital during a program period.

(f) Payments shall be made to a converted hospital that converts during a subject fiscal quarter by multiplying the hospital's supplemental payment as calculated in subdivision (b) by the number of days that the hospital was a private hospital in the subject fiscal quarter, divided by the number of days in the subject fiscal quarter. Payments shall not be made to a converted hospital in any subsequent subject fiscal quarter.

SEC. 30. Section 14169.56 of the Welfare and Institutions Code is amended to read:

14169.56. (a) The department shall increase capitation payments to Medi-Cal managed health care plans for each subject fiscal year as set forth in this section.

(b) (1) Subject to the limitation in paragraph (2), the increased capitation payments shall be made as part of the monthly capitated payments made by the department to managed health care plans. The aggregate amount of increased capitation payments to all Medi-Cal managed health care plans for each subject fiscal year, or portion thereof, shall be the maximum amount for which federal financial participation is available on an aggregate statewide basis for the applicable subject fiscal year within a program period, or portion thereof.

(2) (A) The limitation in subparagraph (B) shall be applied with respect to a subject fiscal year or portion thereof for which the federal matching assistance percentage is less than 90 percent for expenditures for services furnished to individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)).

(B) During a subject fiscal year or portion thereof described in subparagraph (A), the aggregate amount of the increased capitation payments under this section shall not exceed the aggregate amount of the increased capitation payments that would be made if the nonfederal share of the increased capitation payments were the amount that the nonfederal share would have been if the federal matching assistance percentage were 90 percent for expenditures for services furnished to individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)).

(c) The department shall determine the amount of the increased capitation payments for each managed health care plan for each subject fiscal year or portion thereof during a program period. The department shall consider the composition of Medi-Cal enrollees in the plan, the anticipated utilization of hospital services by the plan's Medi-Cal enrollees, and other factors that the department determines are reasonable and appropriate to ensure access to high-quality hospital services by the plan's enrollees.

(d) The amount of increased capitation payments to each Medi-Cal managed health care plan shall not exceed an amount that results in capitation payments that are certified by the state's actuary as meeting federal requirements, taking into account the requirement that all of the increased capitation payments under this section shall be paid by the Medi-Cal managed health care plans to hospitals for hospital services to Medi-Cal enrollees of the plan.

(e) (1) The increased capitation payments to managed health care plans under this section shall be made to support the

availability of hospital services and ensure access to hospital services for Medi-Cal beneficiaries. The increased capitation payments to managed health care plans shall commence within 90 days after the date on which all necessary federal approvals have been received, and shall include, but not be limited to, the sum of the increased payments for all prior months for which payments are due.

(2) To secure the necessary funding for the payment or payments made pursuant to paragraph (1), the department may accumulate funds in the fund, for the purpose of funding managed health care capitation payments under this article regardless of the date on which capitation payments are scheduled to be paid in order to secure the necessary total funding for managed health care payments by the end of a program period.

(f) Payments to managed health care plans that would be paid consistent with actuarial certification and enrollment in the absence of the payments made pursuant to this section, including, but not limited to, payments described in Section 14182.15, shall not be reduced as a consequence of payments under this section.

(g) (1) Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section on hospital services as provided in Section 14169.57.

(2) The department may issue change orders to amend contracts with managed health care plans as needed to adjust monthly capitation payments in order to implement this section.

(3) For entities contracting with the department pursuant to Article 2.91 (commencing with Section 14089), any incremental increase in capitation rates pursuant to this section shall not be subject to negotiation and approval by the department.

(h) (1) In the event federal financial participation is not available for all of the increased capitation payments determined for a month pursuant to this section for any reason, the increased capitation payments mandated by this section for that month shall be reduced proportionately to the amount for which federal financial participation is available.

(2) The determination under this subdivision for any month in a program period shall be made after accounting for all federal financial participation necessary for full implementation of Section 14182.15 for that month.

SEC. 31. Section 14169.58 of the Welfare and Institutions Code is amended to read:

14169.58. (a) (1) For the first program period, designated public hospitals shall be paid direct grants in support of health care expenditures, which shall not constitute Medi-Cal payments, and which shall be funded by the quality assurance fee set forth in this article. For the first program period, the aggregate amount of the grants to designated public hospitals funded by the quality assurance fee set forth in this article shall be forty-five million dollars ($45,000,000) in the aggregate for the two subject fiscal quarters in the 2013–14 subject fiscal year, ninety-three million dollars ($93,000,000) for the 2014–15 subject fiscal year, one hundred ten million five hundred thousand dollars ($110,500,000) for the 2015–16 subject fiscal year, and sixty-two million five hundred thousand dollars ($62,500,000) in the aggregate for the two subject fiscal quarters in the 2016–17 subject fiscal year.

(2) (A) Of the direct grant amounts set forth in paragraph (1), the director shall allocate twenty-four million five hundred thousand dollars ($24,500,000) in the aggregate for the two subject fiscal quarters in the 2013–14 subject fiscal year, fifty million five hundred thousand dollars ($50,500,000) for the 2014–15 subject fiscal year, sixty million five hundred thousand dollars ($60,500,000) for the 2015–16 subject fiscal year, and thirty-four million five hundred thousand dollars ($34,500,000) in the aggregate for the two subject fiscal quarters in the 2016–17 subject fiscal year among the designated public hospitals pursuant to a methodology developed in consultation with the designated public hospitals.

(B) Of the direct grant amounts set forth in subparagraph (A), the director shall distribute six million one hundred twenty-five thousand dollars ($6,125,000) for each subject fiscal quarter in the 2013–14 subject fiscal year, six million three hundred twelve thousand five hundred dollars ($6,312,500) for each subject fiscal quarter in the 2014–15 subject fiscal year, seven million five hundred sixty-two thousand five hundred dollars ($7,562,500) for each subject fiscal quarter in the 2015–16 subject fiscal year, and eight million six hundred twenty-five thousand dollars ($8,625,000) for each subject fiscal quarter in the 2016–17 subject fiscal year in accordance with the timeframes specified in subdivision (a) of Section 14169.66.

(C) Of the direct grant amounts set forth in subparagraph (A), the director shall distribute six million one hundred twenty-five thousand dollars ($6,125,000) for each subject fiscal quarter in the 2013–14 subject fiscal year, six million three hundred twelve thousand five hundred dollars ($6,312,500) for each subject fiscal quarter in the 2014–15 subject fiscal year, seven million five hundred sixty-two thousand five hundred dollars ($7,562,500) for each subject fiscal quarter in the 2015–16 subject fiscal year, and eight million six hundred twenty-five thousand dollars ($8,625,000) for each subject fiscal quarter in the 2016–17 subject fiscal year only upon 100 percent of the rate range increases being distributed to managed health care plans pursuant to subparagraph (D) for the respective subject fiscal quarter. If the rate range increases pursuant to subparagraph (D) are distributed to managed health care plans, the direct grant amounts described in this subparagraph shall be distributed to designated public hospitals no later than 30 days after the rate range increases have been distributed to managed health care plans pursuant to subparagraph (D).

(D) Of the direct grant amounts set forth in paragraph (1), twenty million five hundred thousand dollars ($20,500,000) in the aggregate for the two subject fiscal quarters in the 2013–14 subject fiscal year, forty-two million five hundred thousand dollars ($42,500,000) for the 2014–15 subject fiscal year, fifty million dollars ($50,000,000) for the 2015–16 subject fiscal year, and twenty-eight million dollars ($28,000,000) in the aggregate for the two subject fiscal quarters in the 2016–17 subject fiscal year shall be withheld from payment to the designated public hospitals by the director, and shall be used as the nonfederal share for rate range increases, as defined in paragraph (4) of subdivision (b) of Section 14301.4, to risk-based payments to managed care health plans that contract with the department to serve counties where a designated public hospital is located. The rate range increases shall apply to managed care rates for beneficiaries other than newly eligible beneficiaries, as defined in subdivision (s) of Section 17612.2, and shall enable plans to compensate hospitals for Medi-Cal health services and to support the Medi-Cal program. Each managed health care plan shall expend 100 percent of the rate range increases on hospital services within 30 days of receiving the increased payments. Rate range increases funded under this subparagraph

shall be allocated among plans pursuant to a methodology developed in consultation with the hospital community.

(3) Notwithstanding any other provision of law, any amounts withheld from payment to the designated public hospitals by the director as the nonfederal share for rate range increases, including those described in subparagraph (D) of paragraph (2), shall not be considered hospital fee direct grants as defined under subdivision (k) of Section 17612.2 and shall not be included in the determination under paragraph (1) of subdivision (a) of Section 17612.3.

(b) (1) For the first program period, nondesignated public hospitals shall be paid direct grants in support of health care expenditures, which shall not constitute Medi-Cal payments, and which shall be funded by the quality assurance fee set forth in this article. For the first program period, the aggregate amount of the grants funded by the quality assurance fee set forth in this article to nondesignated public hospitals shall be twelve million five hundred thousand dollars ($12,500,000) in the aggregate for two subject fiscal quarters in the 2013–14 subject fiscal year, twenty-five million dollars ($25,000,000) for the 2014–15 subject fiscal year, thirty million dollars ($30,000,000) for the 2015–16 subject fiscal year, and seventeen million five hundred thousand dollars ($17,500,000) in the aggregate for the two subject fiscal quarters in the 2016–17 subject fiscal year.

(2) (A) Of the direct grant amounts set forth in paragraph (1), the director shall allocate two million five hundred thousand dollars ($2,500,000) in the aggregate for the two subject fiscal quarters in the 2013–14 subject fiscal year, five million dollars ($5,000,000) for the 2014–15 subject fiscal year, six million dollars ($6,000,000) for the 2015–16 subject fiscal year, and three million five hundred thousand dollars ($3,500,000) in the aggregate for the two subject fiscal quarters in the 2016–17 subject fiscal year among the nondesignated public hospitals pursuant to a methodology developed in consultation with the nondesignated public hospitals.

(B) Of the direct grant amounts set forth in paragraph (1), ten million dollars ($10,000,000) in the aggregate for the two subject fiscal quarters in the 2013–14 subject fiscal year, twenty million dollars ($20,000,000) for the 2014–15 subject fiscal year, twenty-four million dollars ($24,000,000) for the 2015–16 subject fiscal year, and fourteen million dollars ($14,000,000) in the

aggregate for the two subject fiscal quarters in the 2016–17 subject fiscal year shall be withheld from payment to the nondesignated public hospitals by the director, and shall be used as the nonfederal share for rate range increases, as defined in paragraph (4) of subdivision (b) of Section 14301.4, to risk-based payments to managed care health plans that contract with the department. The rate range increases shall enable plans to compensate hospitals for Medi-Cal health services and to support the Medi-Cal program. Each managed health care plan shall expend 100 percent of the rate range increases on hospital services within 30 days of receiving the increased payments. Rate range increases funded under this subparagraph shall be allocated among plans pursuant to a methodology developed in consultation with the hospital community.

(c) If the amounts set forth in this section for rate range increases are not actually used for rate range increases as described in this section, the direct grant amounts set forth in this section that are withheld pursuant to subparagraph (D) of paragraph (2) of subdivision (a) and subparagraph (B) of paragraph (2) of subdivision (b) shall be returned to the fund subject to paragraph (4) of subdivision (*l*) of Section 14169.52.

(d) For subsequent program periods, designated public hospitals and nondesignated public hospitals may be paid direct grants pursuant to subdivision (e) of Section 14169.59 upon appropriation in the annual Budget Act.

SEC. 32. Section 14169.59 of the Welfare and Institutions Code is amended to read:

14169.59. (a) The department shall determine during each rebase calculation year the number of subject fiscal years in the next program period.

(b) During each rebase calculation year, the department shall retrieve the data, including, but not limited to, the days data source, used to determine the following for the subsequent program period: acute psychiatric days, annual fee-for-service days, annual managed care days, annual Medi-Cal days, fee-for-service days, general acute care days, high acuity days, managed care days, Medi-Cal days, Medi-Cal fee-for-service days, Medi-Cal managed care days, Medi-Cal managed care fee days, outpatient base amount, and transplant days. The department shall pull data from the most

recent base calendar year for which the department determines reliable data is available for all hospitals.

(c) (1) During each rebase calculation year, the department shall determine all of the following supplemental payment rates for the subsequent program period, which supplemental payment rates shall be specified in provisional language in the annual Budget Act:

(A) The acute psychiatric per diem supplemental rate for each subject fiscal year during the program period.

(B) The general acute care per diem supplemental rate for each subject fiscal year during the program period.

(C) The high acuity per diem supplemental rate for each subject fiscal year during the program period.

(D) The high acuity trauma per diem supplemental rate for each subject fiscal year during the program period.

(E) The outpatient supplemental rate for each subject fiscal year during the program period.

(F) The subacute supplemental rate for each subject fiscal year during the program period.

(G) The transplant per diem supplemental rate for each subject fiscal year during the program period.

(2) During each rebase calculation year, the department shall determine all of the following fee rates for the subsequent program period, which fee rates shall be specified in provisional language in the annual Budget Act:

(A) The fee-for-service per diem quality assurance fee rate for each subject fiscal year during the program period.

(B) The managed care per diem quality assurance fee rate for each subject fiscal year during the program period.

(C) The Medi-Cal per diem quality assurance fee rate for each subject fiscal year during the program period.

(D) The prepaid health plan hospital managed care per diem quality assurance fee rate for each subject fiscal year during the program period.

(E) The prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate for each subject fiscal year during the program period.

(d) The department shall determine the rates set forth in subdivision (c) based on the data retrieved pursuant to subdivision (b). Each rate determined by the department shall be the same for

all hospitals to which the rate applies. These rates shall be specified in provisional language in the annual Budget Act. The department shall determine the rates in accordance with all of the following:

(1) The rates shall meet the requirements of federal law and be established in a manner to obtain federal approval.

(2) The department shall consult with the hospital community in determining the rates.

(3) The supplemental payments and other Medi-Cal payments for hospital outpatient services furnished by private hospitals for each fiscal year shall equal as close as possible the applicable federal upper payment limit.

(4) The supplemental payments and other Medi-Cal payments for hospital inpatient services furnished by private hospitals for each fiscal year shall equal as close as possible the applicable federal upper payment limit.

(5) The increased capitation payments to managed health care plans shall result in the maximum payments to the plans permitted by federal law.

(6) The quality assurance fee proceeds shall be adequate to make the expenditures described in this article, but shall not be more than necessary to make the expenditures.

(7) The relative values of per diem supplemental payment rates to one another for the various categories of patient days shall be generally consistent with the relative values during the first program period under this article.

(8) The relative values of per diem fee rates to one another for the various categories of patient days shall be generally consistent with the relative values during the first program period under this article.

(9) The rates shall result in supplemental payments and quality assurance fees that are consistent with the purposes of this article.

(e) During each rebase calculation year, the director shall determine the amounts and allocation methodology, if any, of direct grants to designated public hospitals and nondesignated public hospitals for each subject fiscal year in a program period, in consultation with the hospital community. The amounts and allocation methodology may include a withholding of direct grants to be used as the nonfederal share for rate range increases. These amounts shall be specified in provisional language in the annual Budget Act.

(f) (1) Notwithstanding any other provision in this article, the following shall apply to the first program period under this article:

(A) The first program period under this article shall be the period from January 1, 2014, to December 31, 2016, inclusive.

(B) The acute psychiatric days shall be those identified in the Final Medi-Cal Utilization Statistics for the 2012–13 state fiscal year as calculated by the department as of December 17, 2012.

(C) The days data source shall be the hospital's Annual Financial Disclosure Report filed with the Office of Statewide Health Planning and Development as of June 6, 2013, for its fiscal year ending during the 2010 calendar year.

(D) The general acute care days shall be those identified in the 2010 calendar year, as reflected in the state paid claims file on April 26, 2013.

(E) The high acuity days shall be those paid during the 2010 calendar year, as reflected in the state paid claims file prepared by the department on April 26, 2013.

(F) The Medi-Cal managed care days shall be those identified in the Final Medi-Cal Utilization Statistics for the 2012–13 fiscal year, as calculated by the department as of December 17, 2012.

(G) The outpatient base amount shall be those payments for outpatient services made to a hospital in the 2010 calendar year, as reflected in the state paid claims files prepared by the department on April 26, 2013.

(H) The transplant days shall be those identified in the 2010 Patient Discharge Data File Documentation from the Office of Statewide Health Planning and Development accessed on June 28, 2011.

(I) With respect to a hospital described in subdivision (f) of Section 14165.50, both of the following shall apply:

(i) The hospital shall not be considered a new hospital as defined in Section 14169.51 for the purposes of this article.

(ii) To the extent permitted by federal law and other federal requirements, the department shall use the best available and reasonable current estimates or projections made with respect to the hospital for an annual period as the data, including, but not limited to, the days data source and data described as being derived from a state paid claims file, used for all purposes, including, but not limited to, the calculation of supplemental payments and the quality assurance fee. The estimates and projections shall be

deemed to reflect paid claims and shall be used for each data element regardless of the time period otherwise applicable to the data element. The data elements include, but are not limited to, acute psychiatric days, annual fee-for-service days, annual managed care days, annual Medi-Cal days, fee-for-service days, general acute care days, high acuity days, managed care days, Medi-Cal days, Medi-Cal fee-for-service days, Medi-Cal managed care days, Medi-Cal managed care fee days, outpatient base amount, and transplant days.

(2) Notwithstanding any other provision in this article, the following shall apply to determine the supplemental payment rates for the first program period:

(A) The acute psychiatric per diem supplemental rate shall be nine hundred sixty-five dollars ($965) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, nine hundred seventy dollars ($970) for the subject fiscal quarters in the 2014–15 subject fiscal year, nine hundred seventy-five dollars ($975) for the subject fiscal quarters in the 2015–16 subject fiscal year and nine hundred seventy-five dollars ($975) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(B) The general acute care per diem supplemental rate shall be eight hundred twenty-four dollars and forty cents ($824.40) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, one thousand one hundred ten dollars and sixty-seven cents ($1,110.67) for the subject fiscal quarters in the 2014–15 subject fiscal year, one thousand three hundred thirty-five dollars and forty-two cents ($1,335.42) for the subject fiscal quarters in the 2015–16 subject fiscal year, and one thousand four hundred forty-one dollars and twenty cents ($1,441.20) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(C) The high acuity per diem supplemental rate shall be two thousand five hundred dollars ($2,500) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, two thousand five hundred dollars ($2,500) for the subject fiscal quarters in the 2014–15 subject fiscal year, two thousand five hundred dollars ($2,500) for the subject fiscal quarters in the 2015–16 subject fiscal year, and two thousand five hundred dollars ($2,500) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(D) The high acuity trauma per diem supplemental rate shall be two thousand five hundred dollars ($2,500) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, two thousand five hundred dollars ($2,500) for the subject fiscal quarters in the 2014–15 subject fiscal year, two thousand five hundred dollars ($2,500) for the subject fiscal quarters in the 2015–16 subject fiscal year, and two thousand five hundred dollars ($2,500) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(E) The outpatient supplemental rate shall be 119 percent of the outpatient base amount for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, 268 percent of the outpatient base amount for the subject fiscal quarters in the 2014–15 subject fiscal year, 292 percent of the outpatient base amount for the subject fiscal quarters in the 2015–16 subject fiscal year, and 151 percent of the outpatient base amount for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(F) The subacute supplemental rate shall be 50 percent for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, 55 percent for the subject fiscal quarters in the 2014–15 subject fiscal year, 60 percent for the subject fiscal quarters in the 2015–16 subject fiscal year, and 60 percent for the first two subject fiscal quarters in the 2016–17 subject fiscal year of the Medi-Cal subacute payments paid by the department to the hospital during the 2010 calendar year, as reflected in the state paid claims file prepared by the department on April 26, 2013.

(G) The transplant per diem supplemental rate shall be two thousand five hundred dollars ($2,500) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, two thousand five hundred dollars ($2,500) for the subject fiscal quarters in the 2014–15 subject fiscal year, two thousand five hundred dollars ($2,500) for the subject fiscal quarters in the 2015–16 subject fiscal year, and two thousand five hundred dollars ($2,500) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(3) Notwithstanding any other provision in this article, the following shall apply to determine the fee rates for the first program period:

(A) The fee-for-service per diem quality assurance fee rate shall be three hundred seventy-four dollars and ninety-one cents

($374.91) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, four hundred twenty-five dollars and twenty-two cents ($425.22) for the subject fiscal quarters in the 2014–15 subject fiscal year, four hundred eighty dollars and eleven cents ($480.11) for the subject fiscal quarters in the 2015–16 subject fiscal year, and five hundred forty-two dollars and ten cents ($542.10) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(B) The managed care per diem quality assurance fee rate shall be one hundred forty-five dollars ($145) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, one hundred forty-five dollars ($145) for the subject fiscal quarters in the 2014–15 subject fiscal year, one hundred seventy dollars ($170) for the subject fiscal quarters in the 2015–16 subject fiscal year, and one hundred seventy dollars ($170) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(C) The Medi-Cal per diem quality assurance fee rate shall be four hundred fifty-seven dollars and ten cents ($457.10) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, four hundred ninety-seven dollars and eight cents ($497.08) for the subject fiscal quarters in the 2014–15 subject fiscal year, five hundred sixty-eight dollars and fifteen cents ($568.15) for the subject fiscal quarters in the 2015–16 subject fiscal year, and six hundred eighteen dollars and fourteen cents ($618.14) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(D) The prepaid health plan hospital managed care per diem quality assurance fee rate shall be eighty-one dollars and twenty cents ($81.20) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, eighty-one dollars and twenty cents ($81.20) for the subject fiscal quarters in the 2014–15 subject fiscal year, ninety-five dollars and twenty cents ($95.20) for the subject fiscal quarters in the 2015–16 subject fiscal year, and ninety-five dollars and twenty cents ($95.20) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(E) The prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate shall be two hundred fifty-five dollars and ninety-seven cents ($255.97) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, two hundred seventy-eight dollars and thirty-seven cents ($278.37) for the subject fiscal quarters in the 2014–15 subject fiscal year, three

hundred eighteen dollars and sixteen cents ($318.16) for the subject fiscal quarters in the 2015–16 subject fiscal year, and three hundred forty-six dollars and sixteen cents ($346.16) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(F) Upon federal approval or conditional federal approval described in Section 14169.63, the director shall have the discretion to revise the fee-for-service per diem quality assurance fee rate, the managed care per diem quality assurance fee rate, the Medi-Cal per diem quality assurance fee rate, the prepaid health plan hospital managed care per diem quality assurance fee rate, or the prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate, based on the funds required to make the payments specified in this article, in consultation with the hospital community.

(g) Notwithstanding any other provision in this article, the following shall apply to the second program period under this article:

(1) The second program period under this article shall begin on January 1, 2017, and shall end on June 30, 2019.

(2) The retrieval date shall occur between October 1, 2016, and December 31, 2016.

(3) The base calendar year shall be the 2013 calendar year, or a more recent calendar year for which the department determines reliable data is available.

(4) The rebase calculation year shall be the 2015–16 state fiscal year.

(5) With respect to a hospital described in subdivision (f) of Section 14165.50, both of the following shall apply:

(A) The hospital shall not be considered a new hospital as defined in subdivision (ai) of Section 14169.51 for the purposes of this article.

(B) To the extent permitted by federal law or other federal requirements, the department shall use the best available and reasonable current estimates or projections made with respect to the hospital for an annual period as to the data, including, but not limited to, the days data source and data described as being derived from a state paid claims file, used for all purposes, including, but not limited to, the calculation of supplemental payments and the quality assurance fee. The estimates and projections shall be deemed to reflect paid claims and shall be used for each data

element regardless of the time period otherwise applicable to the data element. The data elements include, but are not limited to, acute psychiatric days, annual fee-for-service days, annual managed care days, annual Medi-Cal days, fee-for-service days, general acute care days, high acuity days, managed care days, Medi-Cal days, Medi-Cal fee-for-service days, Medi-Cal managed care days, Medi-Cal managed care fee days, outpatient base amount, and transplant days.

(h) Commencing January 2016, the department shall provide a clear narrative description along with fiscal detail in the Medi-Cal estimate package, submitted to the Legislature in January and May of each year, of all of the calculations made by the department pursuant to this section for the second program period and every program period thereafter.

SEC. 33. Section 14169.61 of the Welfare and Institutions Code is amended to read:

14169.61. (a) (1) Except as provided in this section, all data and other information relating to a hospital that are used for the purposes of this article, including, without limitation, the days data source, shall continue to be used to determine the payments to that hospital, regardless of whether the hospital has undergone one or more changes of ownership.

(2) All supplemental payments to a hospital under this article shall be made to the licensee of a hospital on the date the supplemental payment is made. All quality assurance fee payments under this article shall be paid by the licensee of a hospital on the date the quarterly quality assurance fee payment is due.

(b) The data of separate facilities prior to a consolidation shall be aggregated for the purposes of this article if: (1) a private hospital consolidates with another private hospital, (2) the facilities operate under a consolidated hospital license, (3) data for a period prior to the consolidation is used for purposes of this article, and (4) neither hospital has had a change of ownership on or after the effective date of this article unless paragraph (2) of subdivision (d) has been satisfied by the new owner. Data of a facility that was a separately licensed hospital prior to the consolidation shall not be included in the data, including the days data source, for the purpose of determining payments to the facility or the quality assurance fees due from the facility under the article for any time period during which the facility is closed. A facility shall be

deemed to be closed for purposes of this subdivision on the first day of any period during which the facility has no general acute, psychiatric, or rehabilitation inpatients for at least 30 consecutive days. A facility that has been deemed to be closed under this subdivision shall no longer be deemed to be closed on the first subsequent day on which it has general acute, psychiatric, or rehabilitation inpatients.

(c) The payments to a hospital under this article shall not be made, and the quality assurance fees shall not be due, for any period during which the hospital is closed. A hospital shall be deemed to be closed on the first day of any period during which the hospital has no general acute, psychiatric, or rehabilitation inpatients for at least 30 consecutive days. A hospital that has been deemed to be closed under this subdivision shall no longer be deemed to be closed on the first subsequent day on which it has general acute, psychiatric, or rehabilitation inpatients. Payments under this article to a hospital and installment payments of the aggregate quality assurance fee due from a hospital that is closed during any portion of a subject fiscal quarter shall be reduced by applying a fraction, expressed as a percentage, the numerator of which shall be the number of days during the applicable subject fiscal quarter that the hospital is closed during the subject fiscal year and the denominator of which shall be the number of days in the subject fiscal quarter.

(d) The following provisions shall apply only for purposes of this article, and shall have no application outside of this article nor shall they affect the assumption of any outstanding monetary obligation to the Medi-Cal program:

(1) The director shall develop and describe in provider bulletins and on the department's Internet Web site a process by which the new operator of a hospital that has a days data source in whole or in part from a previous operator may enter into an agreement with the department to confirm that it is financially responsible or to become financially responsible to the department for the outstanding monetary obligation to the Medi-Cal program of the previous operator in order to avoid being classified as a new hospital for purposes of this article. This process shall be available for changes of ownership that occur before, on, or after January 1, 2014, but only in regard to payments under this article and otherwise shall have no retroactive effect.

(2) The outstanding monetary obligation referred to in subdivision (ai) of Section 14169.51 shall include responsibility for all of the following:

(A) Payment of the quality assurance fee established pursuant to this article.

(B) Known overpayments that have been asserted by the department or its fiscal intermediary by sending a written communication that is received by the hospital prior to the date that the new operator becomes the licensee of the hospital.

(C) Overpayments that are asserted after such date and arise from customary reconciliations of payments, such as cost report settlements, and, with the exception of overpayments described in subparagraph (B), shall exclude liabilities arising from the fraudulent or intentionally criminal act of a prior operator if the new operator did not knowingly participate in or continue the fraudulent or criminal act after becoming the licensee.

(3) The department shall have the discretion to determine whether the new owner properly and fully agreed to be financially responsible for the outstanding monetary obligation in connection with the Medi-Cal program and seek additional assurances as the department deems necessary, except that a new owner that executes an agreement with the department to be financially responsible for the monetary obligations as described in paragraph (1) shall be conclusively deemed to have agreed to be financially responsible for the outstanding monetary obligation in connection with the Medi-Cal program. The department shall have the discretion to establish the terms for satisfying the outstanding monetary obligation in connection with the Medi-Cal program, including, but not limited to, recoupment from amounts payable to the hospital under this section.

SEC. 34. Section 14169.63 of the Welfare and Institutions Code is amended to read:

14169.63. (a) Notwithstanding any other provision of this article requiring federal approvals, the department may impose and collect the quality assurance fee and may make payments under this article, including increased capitation payments, based upon receiving a letter from the federal Centers for Medicare and Medicaid Services or the United States Department of Health and Human Services that indicates likely federal approval, but only if

and to the extent that the letter is sufficient as set forth in subdivision (b).

(b) In order for the letter to be sufficient under this section, the director shall find that the letter meets both of the following requirements:

(1) The letter is in writing and signed by an official of the federal Centers for Medicare and Medicaid Services or an official of the United States Department of Health and Human Services.

(2) The director, after consultation with the hospital community, has determined, in the exercise of his or her sole discretion, that the letter provides a sufficient level of assurance to justify advanced implementation of the fee and payment provisions.

(c) Nothing in this section shall be construed as modifying the requirement under Section 14169.69 that payments shall be made only to the extent a sufficient amount of funds collected as the quality assurance fee are available to cover the nonfederal share of those payments.

(d) Upon notice from the federal government that final federal approval for the fee model under this article or for the supplemental payments to private hospitals under Section 14169.54 or 14169.55 has been denied, any fees collected pursuant to this section shall be refunded and any payments made pursuant to this article shall be recouped, including, but not limited to, supplemental payments and grants, increased capitation payments, payments to hospitals by health care plans resulting from the increased capitation payments, and payments for the health care coverage of children. To the extent fees were paid by a hospital that also received payments under this section, the payments may first be recouped from fees that would otherwise be refunded to the hospital prior to the use of any other recoupment method allowed under law.

(e) Any payment made pursuant to this section shall be a conditional payment until final federal approval has been received.

(f) The director shall have broad authority under this section to collect the quality assurance fee for an interim period after receipt of the letter described in subdivision (a) pending receipt of all necessary federal approvals. This authority shall include discretion to determine both of the following:

(1) Whether the quality assurance fee should be collected on a full or pro rata basis during the interim period.

(2) The dates on which payments of the quality assurance fee are due.

(g) The department may draw against the fund for all administrative costs associated with implementation under this article, consistent with subdivision (b) of Section 14169.53.

(h) This section shall be implemented only to the extent federal financial participation is not jeopardized by implementation prior to the receipt of all necessary final federal approvals.

SEC. 35. Section 14169.65 of the Welfare and Institutions Code is amended to read:

14169.65. (a) Upon receipt of a letter that indicates likely federal approval that the director determines is sufficient for implementation under Section 14169.63, or upon the receipt of federal approval, the following shall occur:

(1) To the maximum extent possible, and consistent with the availability of funds in the fund, the department shall make all of the payments under Sections 14169.54, 14169.55, and 14169.56, including, but not limited to, supplemental payments and increased capitation payments, prior to the end of a program period, except that the increased capitation payments under Section 14169.56 shall not be made until federal approval is obtained for these payments.

(2) The department shall make supplemental payments to hospitals under this article consistent with the timeframe described in Section 14169.66 or a modified timeline developed pursuant to Section 14169.64.

(b) If any payment or payments made pursuant to this section are found to be inconsistent with federal law, the department shall recoup the payments by means of withholding or any other available remedy.

(c) This section shall not affect the department’s ongoing authority to continue, after the end of a program period, to collect quality assurance fees imposed on or before the end of the program period.

SEC. 36. Section 14169.66 of the Welfare and Institutions Code is amended to read:

14169.66. The department shall make disbursements from the fund consistent with the following:

(a) Fund disbursements shall be made periodically within 15 days of each date on which quality assurance fees are due from hospitals.

(b) The funds shall be disbursed in accordance with the order of priority set forth in subdivision (b) of Section 14169.53, except that funds may be set aside for increased capitation payments to managed care health plans pursuant to subdivision (e) of Section 14169.56.

(c) The funds shall be disbursed in each payment cycle in accordance with the order of priority set forth in subdivision (b) of Section 14169.53 as modified by subdivision (b), and so that the supplemental payments and direct grants to hospitals and the increased capitation payments to managed health care plans are made to the maximum extent for which funds are available.

(d) To the maximum extent possible, consistent with the availability of funds in the fund and the timing of federal approvals, the supplemental payments and direct grants to hospitals and increased capitation payments to managed health care plans under this article shall be made before the last day of a program period.

(e) The aggregate amount of funds to be disbursed to private hospitals shall be determined under Sections 14169.54 and 14169.55. The aggregate amount of funds to be disbursed to managed health care plans shall be determined under Section 14169.56. The aggregate amount of direct grants to designated and nondesignated public hospitals shall be determined under Section 14169.58.

SEC. 37. Section 14169.72 of the Welfare and Institutions Code is amended to read:

14169.72. This article shall become inoperative if any of the following occurs:

(a) The effective date of a final judicial determination made by any court of appellate jurisdiction or a final determination by the United States Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services that the quality assurance fee established pursuant to this article, or Section 14169.54 or 14169.55, cannot be implemented. This subdivision shall not apply to any final judicial determination made by any court of appellate jurisdiction in a case brought by hospitals located outside the state.

(b) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve on or before the last day of a program period, the implementation of Sections 14169.52, 14169.53, 14169.54, and 14169.55, and the department fails to modify Section 14169.52, 14169.53, 14169.54, or 14169.55 pursuant to subdivision (d) of Section 14169.53 in order to meet the requirements of federal law or to obtain federal approval.

(c) A final judicial determination by the California Supreme Court or any California Court of Appeal that the revenues collected pursuant to this article that are deposited in the fund are either of the following:

(1) "General Fund proceeds of taxes appropriated pursuant to Article XIII B of the California Constitution," as used in subdivision (b) of Section 8 of Article XVI of the California Constitution.

(2) "Allocated local proceeds of taxes," as used in subdivision (b) of Section 8 of Article XVI of the California Constitution.

(d) The department has sought but has not received federal financial participation for the supplemental payments and other costs required by this article for which federal financial participation has been sought.

(e) A lawsuit related to this article is filed against the state and a preliminary injunction or other order has been issued that results in a financial disadvantage to the state. For purposes of this subdivision, "financial disadvantage to the state" means either of the following:

(1) A loss of federal financial participation.

(2) A cost to the General Fund that is equal to or greater than one-quarter of 1 percent of the General Fund expenditures authorized in the most recent annual Budget Act.

(f) The proceeds of the fee and any interest and dividends earned on deposits are not deposited into the fund or are not used as provided in Section 14169.53.

(g) The proceeds of the fee, the matching amount provided by the federal government, and interest and dividends earned on deposits in the fund are not used as provided in Section 14169.68.

SEC. 38. Section 14312 of the Welfare and Institutions Code is amended to read:

14312. The director shall adopt all necessary rules and regulations to carry out the provisions of this chapter. In adopting

such rules and regulations, the director shall be guided by the needs of eligible persons as well as prevailing practices in the delivery of health care on a prepaid basis. Except where otherwise required by federal law or by this part, the rules and regulations shall be consistent with the requirements of the Knox-Keene Health Care Service Plan Act of 1975.

SEC. 39. Section 14451 of the Welfare and Institutions Code is amended to read:

14451. Services under a prepaid health plan contract shall be provided in accordance with the requirements of the Knox-Keene Health Care Service Plan Act of 1975.

SEC. 40. Section 15657.8 of the Welfare and Institutions Code is amended to read:

15657.8. (a) An agreement to settle a civil action for physical abuse, as defined in Section 15610.63, neglect, as defined in Section 15610.57, or financial abuse, as defined in Section 15610.30, of an elder or dependent adult shall not include any of the following provisions, whether the agreement is made before or after filing the action:

(1) A provision that prohibits any party to the dispute from contacting or cooperating with the county adult protective services agency, the local law enforcement agency, the long-term care ombudsman, the California Department of Aging, the Department of Justice, the Licensing and Certification Division of the State Department of Public Health, the State Department of Developmental Services, the State Department of State Hospitals, a licensing or regulatory agency that has jurisdiction over the license or certification of the defendant, any other governmental entity, a protection and advocacy agency, as defined in Section 4900, or the defendant's current employer if the defendant's job responsibilities include contact with elders, dependent adults, or children, provided that the party contacting or cooperating with one of these entities had a good faith belief that the information he or she provided is relevant to the concerns, duties, or obligations of that entity.

(2) A provision that prohibits any party to the dispute from filing a complaint with, or reporting any violation of law to, the county adult protective services agency, the local law enforcement agency, the long-term care ombudsman, the California Department of Aging, the Department of Justice, the Licensing and Certification

Division of the State Department of Public Health, the State Department of Developmental Services, the State Department of State Hospitals, a licensing or regulatory agency that has jurisdiction over the license or certification of the defendant, any other governmental entity, a protection and advocacy agency, as defined in Section 4900, or the defendant's current employer if the defendant's job responsibilities include contact with elders, dependent adults, or children.

(3) A provision that requires any party to the dispute to withdraw a complaint he or she has filed with, or a violation he or she has reported to, the county adult protective services agency, the local law enforcement agency, the long-term care ombudsman, the California Department of Aging, the Department of Justice, the Licensing and Certification Division of the State Department of Public Health, the State Department of Developmental Services, the State Department of State Hospitals, a licensing or regulatory agency that has jurisdiction over the license or certification of the defendant, any other governmental entity, a protection and advocacy agency, as defined in Section 4900, or the defendant's current employer if the defendant's job responsibilities include contact with elders, dependent adults, or children.

(b) A provision described in subdivision (a) is void as against public policy.

(c) This section shall apply only to an agreement entered on or after January 1, 2013.

SEC. 41. Section 16541 of the Welfare and Institutions Code is amended to read:

16541. The council shall be comprised of the following members:

(a) The Secretary of California Health and Human Services, who shall serve as cochair.

(b) The Chief Justice of the California Supreme Court, or his or her designee, who shall serve as cochair.

(c) The Superintendent of Public Instruction, or his or her designee.

(d) The Chancellor of the California Community Colleges, or his or her designee.

(e) The executive director of the State Board of Education.

(f) The Director of Social Services.

(g) The Director of Health Care Services.

(h) The Director of State Hospitals.
(i) The Director of Developmental Services.
(j) The Director of the Youth Authority.
(k) The Administrative Director of the Courts.
(*l*) The State Foster Care Ombudsperson.
(m) Four foster youth or former foster youth.
(n) The chairpersons of the Assembly Human Services Committee and the Assembly Judiciary Committee, or two other Members of the Assembly as appointed by the Speaker of the Assembly.
(o) The chairpersons of the Senate Human Services Committee and the Senate Judiciary Committee, or two other members appointed by the President pro Tempore of the Senate.
(p) Leaders and representatives of county child welfare, foster care, health, education, probation, and mental health agencies and departments, child advocacy organizations; labor organizations, recognized professional associations that represent child welfare and foster care social workers, tribal representatives, and other groups and stakeholders that provide benefits, services, and advocacy to families and children in the child welfare and foster care systems, as recommended by representatives of these groups and as designated by the cochairs.

SEC. 42. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to ensure the health and safety of Californians by updating existing law consistent with current practices at the earliest possible time, it is necessary that this act take effect immediately.

Approved _____, 2014

_____

Governor